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VOL. I.—30TH YEAR.

SYDNEY, SATURDAY, MARCH 6, 1943.

No. 11.<sup>10</sup>

COMMONWEALTH OF AUSTRALIA ————— DEPARTMENT OF HEALTH

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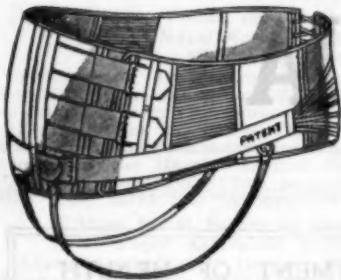
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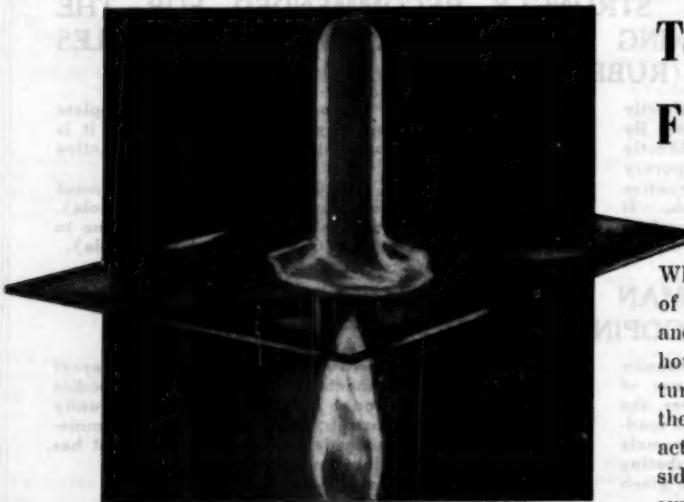
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SUPPLEMENT NUMBER 10 ON WAR MEDICINE AND SURGERY:  
Infected Wounds.

### MEDICAL PLANNING COMMISSION: DRAFT INTERIM REPORT.<sup>1</sup>

#### INTRODUCTION.

1. The Medical Planning Commission was established by the British Medical Association with the co-operation of the Royal Colleges and the Royal Scottish Corporations in August, 1940, with the following terms of reference:

To study wartime developments and their effects on the country's medical services both present and future. 2. The bodies appointing to the Commission, which consists of 73 members, are the British Medical Association, the Royal College of Physicians of London, the Royal College of Surgeons of England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, the Royal Faculty of Physicians and Surgeons of Glasgow, the Society of Medical Officers of Health, the Faculty of Radiologists, the Medical Women's Federation, and the Parliamentary Medical Committee. The members of the Commission have taken part in its work as individuals, and the bodies appointing to the Commission are in no way committed by this report. Observers were appointed by the Ministry of Health, the Department of Health for Scotland, and the Ministry of Home Affairs for Northern Ireland.

3. At its first meeting on May 7, 1941, the Commission established six main Committees, five dealing with more or less clearly defined branches of medical activity, and the sixth co-ordinating the work of the other Committees. The subject Committees are the General Practice, Special Practice, Public Health, Hospitals, and Teaching Hospitals Committees.

4. The five subject Committees, which have met on 31 occasions in all, have considered the principles of medical organization and reorganization within their respective spheres and have submitted reports. The Co-ordination Committee has integrated these reports in one composite document which was presented to the Commission on May 29, 1942. Before discussing any proposals in detail or reaching any conclusions the Commission presents this draft interim report to the bodies represented on the Commission and to the medical profession generally.

The Commission asks that the interim report should be freely discussed by the profession, and that comments and criticisms should be made available to it before it proceeds to formulate definite proposals on the broad principles of medical organization and reorganization. When these comments and criticisms have been received the Commission will revise and complete the interim report, submit it to the Government, publish it, and subsequently work out the details either alone or in collaboration with the main agencies, Governmental and other, interested in or affected by the Commission's recommendations. *The suggestions contained in the present report should not, therefore, be regarded as expressing the Commission's conclusions but as recommendations made to it which the Commission as a whole has not yet considered and will not consider until the profession has made known its views through the usual channels.*

#### OBJECTS OF REFORM IN MEDICAL PRACTICE AND PROVISION.

5. The Commission has adopted for the purpose of its discussion the following broad definition of the objects of medical service in this country:

(a) To provide a system of medical service directed towards the achievement of positive health, the prevention of disease, and the relief of sickness.

(b) To render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional.

#### SOME CRITICISMS OF PRESENT MEDICAL SERVICES.

6. The diffusion of responsibility for the country's health services among a number of statutory central and local authorities is a weakness of the present administrative system. In part the explanation lies in the mode of development of the public health services. Originally established to meet the peril of cholera in 1831, these services were closely associated with public assistance and were centrally supervised or controlled, first by a central Board of Health and later by the Local Government Board. Then the Local Government Board was succeeded by the Ministry of Health as a further expression of the policy of central integration. But the intention of Parliament in 1919 to bring the school medical service within the same ambit was frustrated by the Education Act of 1921, nor were any steps taken to transfer to the Ministry of Health the health functions of some other Government Departments. Thus at the present time civil medical functions are distributed among the

<sup>1</sup> Reprinted from the *British Medical Journal* of June 20, 1942, by permission of the Editor of that journal. See leading article, page 211.

Ministry of Health, the Board of Education, the Home Office, the Ministry of Pensions, the Ministry of Labour, the General Post Office, and the Ministry of Supply.

7. At the beginning of the public health movement such local powers and duties as Parliament imposed for the prevention of disease were at first exercised by the Boards of Guardians created by the Poor Law Act of 1834. The Poor Law played an important part in the early development of the country's medical services, it helped to reduce the incidence of disease among the poor, and it established the principle of the provision of domiciliary medical care at the public expense for any person who was unable to afford to pay for it. The continued existence of the Poor Law system, however, side by side with the system of public health functions developed by local government authorities since the Municipal Corporations Act of 1835 produced many complications which only ended with the absorption of the functions of the Boards of Guardians by the major local authorities on the passing of the Local Government Act of 1929.

8. Central government in Scotland has undergone a similar process of evolution. The Scottish Local Government Board was merged in the Scottish Board of Health in 1919. In turn the latter gave place to the Department of Health for Scotland in 1929, a civil service department directly answerable to the Secretary of State for Scotland. It exercises functions equivalent to those of the Ministry of Health in England and the Welsh Board of Health in Wales. Except for the fact that the central administration of the school medical service is within its sphere, its contact with the departments responsible for the other civil medical services mentioned in paragraph 6 is equally remote.

9. In Northern Ireland no comprehensive Act dealing with health matters has been passed since the Local Government (Ireland) Act of 1898. The English and Scottish Local Government Acts of 1929 and the English Public Health Act of 1936 have no counterpart in Northern Ireland legislation.

10. The fabric of local government has been constantly modified during the past hundred years. To-day the county borough is the only local government unit which is completely self-contained and all-embracing in its public health activities. Outside county boroughs, health functions are shared between county councils and county district councils. For example, while county councils provide general and special hospitals, district councils may also do so, and, in fact, they own most of the hospitals for infectious diseases. The larger boroughs and urban district councils may be responsible for the school medical service, but only if they are education authorities for elementary education. Either the county council or the district council may be the welfare authority under the Maternity and Child Welfare Act of 1918, depending on a more or less accidental decision in 1907. Many of the districts are too small for the efficient and economic management of some of the tasks they have undertaken or have had imposed upon them and the same is true of some of the counties and county boroughs. The Public Health and Local Government Acts give ample facilities for overcoming this difficulty, but local authorities are often unwilling to co-operate and, except for Port Health Authorities and in the case of the Cancer Act, 1939, the machinery for enforcing co-operation is inadequate.

11. Two important statutory medical services are outside the province of the major local authorities. In so far as there is any local control over the administration of National Health Insurance, it rests with the insurance committees of counties and county boroughs. District councils have minor functions in relation to sanitary conditions in factories, but the main responsibility for occupational health lies with the Factory Department of the Ministry of Labour.

12. Similar criticisms have been made of the local government system in Scotland. The country is divided for administrative purposes into counties, cities (Edinburgh, Glasgow, Aberdeen, and Dundee), large burghs (over 20,000 in population), and small burghs. The small burghs have been left with few public health responsibilities since the

passage of the Local Government (Scotland) Act, 1929. The school medical service is entirely in the hands of the councils of the counties and the four cities, but the so-called large burghs retain other public health functions. The Committee on Scottish Health Services mentions as the outstanding defect in local administration "that some of the town and county councils are unable out of their own resources to provide economically and efficiently for water supplies and drainage, hospitals, specialist medical and other services that, in modern conditions, require large administrative units". They show reluctance to combine, in spite of prolonged stimulation from the Department of Health, especially in relation to hospitals.

13. Local health authorities were developed originally to administer sanitary services and to control infectious diseases, but since the early part of the present century they have assumed functions in relation to personal health services—for example, in regard to mothers and children, and to persons suffering from tuberculosis, venereal diseases, mental disease (including mental deficiency), and orthopaedic and other conditions. The structure and practice of local authorities, however, have not been sufficiently modified to adapt them to their changing responsibilities. Further, local authorities have often developed their personal health services without adequate consultation with the profession and without consideration of other authorities, both State and voluntary, working in the same field.

14. The composition of local authorities is also the subject of criticism from the point of view of modern medical services. The members of local authorities are elected by the local population on the basis of local interests or political views and not necessarily for their competence to deal with the problems of modern social services. The rapid advance of medical science and the increasing complexity of medical practice have outstripped the ability of the average local councillor to make informed decisions concerning the provision and management of medical services, and too often policy is determined by local politics and personal factors.

15. In the field of hospital development there is a need for greater co-operation and for machinery to ensure it. The entry of the local authorities, in consequence of the Local Government Act of 1929, into the field of general hospital services has provided a good deal of new accommodation, but, in spite of the opportunity offered for co-operation between voluntary and council hospitals, the deficiency and maldistribution of hospital accommodation, taking the country as a whole, have not been remedied. Lack or insufficiency of co-operation is apparent between many voluntary and many council authorities, between individual hospitals, and between individual local authorities.

16. The foregoing criticisms may be summed up in the general criticism that there has been no comprehensive national health policy to guide legislative and other developments in the sphere of medical service. The distribution of executive and administrative functions among statutory bodies, both central and local, has been haphazard. There are too many central and local bodies concerned with one or another aspect of the country's health services, and too little collaboration between statutory bodies and between statutory and voluntary bodies. There has been insufficient consultation with the medical profession, both centrally and locally, on those important aspects of health administration upon which it is well fitted to advise. Where advisory machinery, such as the Consultative Councils for England and Wales and for Scotland, has been created it has rarely been utilized.

17. The general public find many grounds for criticism in the provision and distribution of medical services. The benefits of National Health Insurance are restricted to wage-earners, though the needs of the dependants of insured persons and other persons of similar economic status are no less. The benefits of this scheme are also severely limited in that they do not include as statutory benefits consultant, specialist, and institutional services. Another complaint is that economic status rather than medical need is felt to be too often the criterion of eligibility for medical

The distribution of doctors, both general practitioners and specialists, is said to be governed more by the economics of the medical profession than by the medical needs of the various types of area. Consultant and specialist services are not always conveniently available, partly because practitioners engaged in them tend to concentrate in university centres and the large towns. The absence of co-ordination in medical services is a general ground of criticism by the public. The patient who requires treatment that cannot be given by his own doctor expects that his doctor should be able to secure that service for him. In fact, the general practitioner is not always provided with the means of securing for his patients all the treatment they may require.

18. The sense of isolation is one of the chief grievances of the general practitioner. Many statutory authorities charged with personal health functions well within the scope of the general practitioner have preferred to exclude him from their organization. Hospital authorities, both statutory and voluntary, have often failed to foster his good will and to create the machinery necessary for full co-operation and consultation with him. In some directions his sphere of professional activity has been limited to such an extent as to endanger his general efficiency. Though verbal tribute is often paid to the important place of the general practitioner in the pattern of the country's health services, in practice statutory bodies do not generally admit him to partnership with them, and even tend to widen the gap between official medical services and general practice.

19. There is another form of isolation which the general practitioner experiences. The days when a doctor armed only with his stethoscope and his drugs could offer a fairly complete medical service are gone. He cannot now be all-sufficient. For efficient work he must have at his disposal modern facilities for diagnosis and treatment, and often these cannot be provided by a private individual or installed in a private surgery. He must also have easy and convenient access to consultant and specialist opinion, whether at hospital or elsewhere, and he must have opportunities for real collaboration with consultants. Facilities such as these are inadequate at the present time. There must also be close collaboration among local general practitioners themselves, for their different interests and experience can be of value to each other. Although this need is recognized by practitioners collaboration has not been developed as it should be.

20. Other criticisms offered by general practitioners relate to the conditions in which they work. There are insufficient facilities for regular postgraduate study and the development of special scientific and clinical interest. The pressure of work, which may be ascribed in part to bad distribution, often leads to excessive hours of duty and insufficient holidays. Some criticisms of the present system concern finance. A considerable capital outlay is required before a doctor can establish himself in general practice. Those who have to borrow the whole or a large part of the necessary money find the strain very great, and the proportion of practitioners who carry a heavy financial burden in their early years is growing. Various arrangements have been made by insurance companies and others to aid practitioners, but some of them have financially crippled the borrower. The absence of any compulsory or universal financial provisions for retirement and pensions is the subject of complaint. Although such arrangements can be made privately by any practitioner who desires them and can afford them, it is felt that there should be some organized scheme which would give the general practitioner advantages in this respect similar to those enjoyed by practitioners in the public services.

21. Other defects result from the existence side by side of two essentially different hospital systems—the individualistic voluntary hospital depending for its continuance on voluntary enterprise and staffed by medical practitioners who in most cases receive no direct remuneration for their services, and the municipal hospitals administered by local government authorities and staffed by practitioners who are paid officers of the local authorities. Many of the differences that exist between the two systems—such as the conditions of

admission of patients and the opportunities offered for professional careers—are fundamental, and their continued existence is detrimental to the development of an efficient hospital service.

22. These are some of the deficiencies and defects which are stated with varying emphasis by the public and by doctors to exist to-day. While it is not necessary to accept them all as of equal importance or validity, it cannot be denied that there is some foundation for most of them.

#### DISCUSSION.

##### Some Principles.

23. What steps should be taken in the public interest to improve the community's medical services as a whole? Any proposals for reform must have as their object the largest possible measure of improvement in the public health. They must aim at improvement in the quantity, the quality, and the availability of all types of medical service. Doctors must be competent and have time to devote to those medical services which they undertake to give. They must have facilities for rendering them at the highest possible level of efficiency. The public must have access to all services with the maximum amount of convenience and comfort.

24. The reform of the medical and health services of the country should include measures for securing that each family or individual shall be under the care of a medical practitioner who shall be concerned not only with diagnosis and treatment but also with the promotion of health and the prevention of disease. This involves the integration of the preventive and personal health services. It also involves radical changes in the country's administrative machinery and in the training of medical students. It assumes that the fusion of public health and other forms of practice will result in practitioners in every field working in closer contact and accord not only with one another but also with dentists, nurses, midwives, sanitary inspectors, and other auxiliaries.

25. While there is general agreement on the objects desired, there is difference of opinion as to the best way of achieving them. Some maintain that the existing system can be so augmented and rearranged as to provide a comprehensive and wholly satisfactory medical service. Others argue that the ideals of medical service cannot be achieved without radical alterations in the basis of existing services, and suggest that a whole-time salaried service under Government control is essential. A third group favour a combination of private practice and a Government service. There are, however, some fundamental principles of medical service which find general acceptance, and these may be briefly set down before the alternative lines of development are discussed.

##### *The Function of the General Practitioner.*

26. There seems to be general agreement with the view expressed in 1920 by the Consultative Council on Medical and Allied Services of the Scottish Board of Health that the organization of the national health services should be based upon the family as the normal unit and on the family doctor as the normal medical attendant and guardian. The first essential is not institutional but personal service, such as can be rendered by a family doctor who has the continuous care of the health of the families under his charge. To him they will turn for advice and help. He will afford them such professional services as he can render personally, and will make it his duty to see that they obtain full advantage of all the further auxiliary services that may be otherwise provided.

##### *Co-operation in General Practice.*

27. Diverse as are the views on the organization of medical services, there is general agreement that co-operation among individual general practitioners in a locality is essential to efficient practice under modern conditions, though views vary on the form of the co-operation. The principle of the organization of general practice on a group or co-operative basis is widely approved. A convenient term for the focal point of co-operation is "health centre". The general suggestion is that there should be available at local health centres certain facilities

for diagnosis and consultation and, in appropriate areas, facilities for the work now undertaken by general practitioners at their own surgeries and for much of the work now undertaken at local authority clinics. The nature and functions of a health centre are discussed more fully later in this report.

#### *Free Choice.*

28. Some of the proposals for reform appear at first sight to abolish or limit the principle of free choice, which has hitherto been regarded by many people as fundamental to efficient medical practice and to the proper relationship between doctor and patient. It is recognized that there are parts of the country where for geographical reasons free choice of doctor cannot in fact exist, but that does not affect the basic principle. Many of the reasons that bring a patient to a doctor are of psychological origin or involve a psychological factor. A good doctor is as much a friend as a clinician. Unless he has the confidence of his patient he starts with a handicap which renders successful treatment less likely. A patient who is repelled by a doctor, or a doctor who is repelled by a patient, should not be required to continue the association. For these and other reasons it is agreed that as wide a measure as possible of free choice, including the right of a patient to change his doctor and of a doctor not to accept a patient, is essential to a successful medical service.

#### *Hospital Reform.*

29. There is general agreement that the present uncoordinated hospital services should give way to a unified hospital system. Many plans for unification have been put forward, but few of them enter into great detail or face the practical difficulties involved. A number of reformers, for example, propose a complete State-controlled medical service which would presumably absorb the present voluntary hospitals. Others advocate the creation of a national hospital corporation to take over both the voluntary and council hospitals and organize them in a single system. The voluntary hospitals, however, embody traditions and standards of service which should not be allowed to disappear. At the same time it is recognized that the potentialities of the council hospitals are great and that they should be developed. The general view is that from the two separate hospital systems there should be evolved one co-ordinated system, unified centrally and locally, and embodying the best features of both systems. The hospital services, the personal health services, and the general practitioner services should be closely linked.

30. The organization of all hospital services on a regional basis is generally favoured. The idea of regionalization of hospital services is not new. The regionalization of voluntary hospitals, whereby over a given area one authority would supervise and correlate hospital arrangements and needs, was suggested in the report of the Voluntary Hospitals Committee as long ago as 1921. For several years the Department of Health for Scotland has advocated joint action for hospital purposes by local authorities and voluntary bodies over wide regions with teaching centres as their bases. The British Medical Association has urged the grouping of hospitals round a central or base hospital, while the Voluntary Hospitals Commission, set up by the British Hospitals Association in 1935, recommended the division of the country into hospital regions with the formation in each region of an Advisory Council, and the formation of a Central Council, also advisory, to correlate the work of the regions. But perhaps the greatest stimulus towards voluntary regionalization has come from the Nuffield Provincial Hospitals Trust, which was formed in 1939 to promote in the Provinces co-ordination of hospital services on a regional basis. The principle of regionalization on a large scale has been a prominent feature of the Emergency Medical Service.

#### *Possible Lines of Development of Medical Services.*

31. Division of opinion is exhibited in the types of proposals for such reform as will remove the defects and deficiencies of the present system. The three main types—namely, the improvement and development of the existing system, the whole-time salaried medical service, and the

intermediate schemes—are briefly outlined below. The question of hospital reform is dealt with in a subsequent section.

#### *Development of the Existing System.*

32. It is logical to set out first the view of those who believe that, in spite of the admitted defects and omissions of the present system, an endeavour should be made to build for the future on the existing foundations rather than to devise an entirely new structure. It is maintained that the present system is the natural product of the country's social evolution and is suited to the native genius. The National Health Insurance system has stood the test of 30 years and has proved itself fundamentally sound, efficient, and capable of development. The best-known exponent of this view has been the British Medical Association, whose policy was described in its "General Medical Service for the Nation".

33. The scheme provides for a complete general medical service with domiciliary, institutional, maternity, consultant and specialist, and auxiliary services. It proposes the inclusion in the National Health Insurance scheme of the dependants of the present insured persons, those at present receiving domiciliary medical attendance through public assistance machinery, and other persons, with their dependants, of an economic status similar to that of the present insured persons. It is estimated that these groups constitute approximately 90% of the population. For the purpose of administration the supporters of this view envisage the enlargement of the unit of health administration, efficient co-ordination between the different sections of the medical service, and the creation of medical advisory committees representative of the whole profession in each area. Central medical committees would be maintained for the purpose of central consultation or negotiation. The relation of the general practitioner to the State would remain substantially as it is at the present time.

34. Until recently the conception of health centres for general practice had not usually been associated with the policy of maintaining the present system, but the supporters of this policy see no reason why, if the health centre idea is acceptable to the public and the profession, it should not be applied in suitable form to the existing system. Similarly, the conception of regionalization can equally well be applied to the existing system, and even the proposal for a national health board or corporation as the central authority could be introduced without any fundamental break with tradition.

35. The opponents of such evolutionary development maintained that the defects of the present system are inherent and cannot be remedied except by a radical change in the structure. They say that efficient service cannot be obtained from a system where doctors compete for patients, where practice and partnership arrangements are on a business basis, and where general practices are bought and sold—an evil which would be aggravated by the extension of National Health Insurance. This last criticism, however, relating to the sale and purchase of practices, is also made by some of the supporters of evolutionary development. The opponents of the present system further maintain that existing conditions breed suspicion and resentment and friction between doctor and doctor, and between the doctor, the hospital, and the public health authority.

#### *A Whole-Time Salaried Medical Service.*

36. The advocates of a whole-time salaried service base their plan on the thesis that the provision of a medical service, like that of an educational service, is a function of the State, that competition in private medical practice is undesirable and should in time become unnecessary. If the objects defined by the Commission (para. 5) are to be fulfilled there must be provided a complete preventive and curative service, and no question of inability to pay should deter people from obtaining all the benefits inherent in these. While it is possible to finance the scheme either by insurance methods or State funds, the actual provision of the service should be without direct charge upon the patient. The service should be nationally planned and controlled, but administered by regional authorities covering large areas and giving full representation to the

medical profession on advisory councils, local, regional and central; and also providing elasticity and freedom from bureaucratic control in the local health units. The doctor would become a salaried officer with all the benefits which this implies. His advancement and remuneration would be related to length of service and merit and to the nature and responsibilities of the post held.

37. This health service would be organized locally through a system of health centres so placed and staffed as to meet the needs of the population, linked with the hospitals and all specialist services. Health centres would replace, except in remote areas, the doctors' surgeries; organize the work of practitioners and consultants and carry out the work of certain existing clinics; organize the work of the ancillary services, and carry out health education.

38. The opponents of a whole-time salaried medical service say that while direct Government control of some aspects of public service may be practicable, it does not follow that it is desirable in so personal a service as medicine. Each type of service must be judged on its own merits. The opponents of a whole-time Government salaried medical service also fear the intrusion of politics, both national and local, into the field of medical service, an intrusion which they maintain would be disastrous. They hold, further, that the "cold hand" of bureaucratic control, with the doctor acting under the orders of superior officers, whether medical or lay, would be inimical to the wise and humane administration of a personal health service. The free-lance doctor turned civil servant, they say, would suffer a diminution of his sense of personal responsibility for his patient, and he would lose the spur to improved professional work and research. A profession of routine "safe men" would be to the detriment of the country's health and medicine might cease to attract the proportion of first-class men it has attracted hitherto.

39. The apprehension that in a whole-time salaried service the posts carrying the highest salaries and status would be administrative is another ground of objection. If this fear is justified the choice before the practitioner would be whether to aim at a higher salary and divorce himself from clinical medicine for which he was trained or to continue in clinical medicine and be content with a lower salary and status.

40. While a method of whole-time appointments would give practitioners a measure of security they do not at present enjoy, it has many critics. These point out that, human nature being what it is, the desire to improve one's status and one's income is the mainspring of most human effort. As a general rule it is not absent in the whole-time officer; the prospect of promotion or of transfer stimulates him. But, whereas in existing private practice the doctor's prospects of material prosperity depend upon the verdict of the patient—the only person who can directly assess, however imperfectly, the service his doctor is rendering to him—in whole-time public service an administrative officer or a committee of persons of varying capacity are the arbiters. Competition to secure the favour of superior officers or committees involves dangers no less great, if not greater, than those of competition to attract patients.

41. The direct servants of preponderantly lay bodies naturally tend to agree to and promote projects which they themselves would not have propounded. The relation of master and servant sometimes leads to an unconscious loss of independence of thought and sometimes even to a cynical tolerance of lay opinions and policies. No branch of the profession is free from the trammels of the circumstances in which it works, but perhaps whole-time medical officers are more bound by them than private practitioners. It is of this danger that the opponents of a whole-time salaried medical service are apprehensive, though their apprehensions might be lessened if governing bodies were differently composed.

42. The validity of some of the advantages offered by the supporters of a whole-time salaried medical service has been questioned by some persons. For example, the factor of security is widely held to be one of the main advantages of such a service. The critics point out that although medicine might be a Government service, the Government

would not guarantee a post to every person qualifying in medicine. Moreover, although civil servants in the central Government Departments at present enjoy security of tenure subject to good behaviour, most officers appointed by local government authorities do not. Their appointments are subject to a period of notice on either side, and an officer may be displaced as a consequence of changes in the functions and duties of the authority.

43. Again, it seems to be assumed that under a whole-time salaried service a practitioner's hours on duty would be fixed, and outside those hours he would be under no obligation to attend patients. The opponents of the scheme argue that definite and fixed hours of duty could not operate in so personal a service as medicine as they do in many other occupations. If a patient selects or is given a practitioner as his family doctor, that practitioner remains responsible for the health of the patient, and the time of illness will not necessarily coincide with the doctor's periods of duty. He must maintain a continuous responsibility.

44. Another difficulty pointed out by opponents of a whole-time salaried medical service is that, by making medicine a branch of the civil or local government service, the professional medical organizations might suffer the disadvantages observable in certain organizations composed of whole-time officers which are unable in practice, if not in theory, to act with entire freedom from official influence. It is maintained that the independence of the professional medical organizations is a very real asset to medical practitioners in all branches of practice. A further disability, under present law, of whole-time salaried officials is that they are disqualified for public service as elected members of the bodies which appoint them.

#### *The Intermediate Schemes.*

45. Some people who think that a mere extension of the National Health Insurance system would be an inadequate measure of reform are yet not prepared to go so far as to recommend a whole-time salaried medical service. They therefore suggest a service intermediate between the two which would be based primarily on part-time salaried public service with opportunities for private practice. The following outline may be taken as a typical intermediate scheme. Domiciliary medical service for persons with incomes below a certain level, with their dependants, would be free; persons whose income is above the standard "free" level but below another standard figure would have the option of "contracting in" to the service by making payments at regular intervals to a contributory scheme. The young practitioner entering general practice would act as assistant and receive a salary. The salary of the principal would depend upon the number of "public" patients allocated to him, and this in turn would be dependent inversely upon the number of his private patients. The scheme also provides for the appointment of district medical officers with supervisory and consultative functions. An *ad hoc* regional council composed of full-time salaried representatives of local authority hospitals and the local profession would be responsible directly to the central authority for the proper functioning of the domiciliary medical service in its area. The cost of the service would be a direct charge on the Exchequer.

46. To a proportionate extent the objections to a whole-time salaried medical service apply to this scheme. The main objection is to the direct administration by the Government with the consequent atmosphere of officialism.

#### *The Majority View.*

47. The majority view of the committees which have discussed this matter is against a whole-time salaried Government service. It is felt that some of the advocates of a whole-time salaried medical service tend to paint an unduly gloomy picture of present-day medical practice. There have been great improvements in ethical and professional standards since the introduction of National Health Insurance, and, with certain ameliorations and increase of opportunity, the conditions under which the bulk of practitioners work are conducive to efficiency. It is felt by the majority that, while there is obvious and urgent need for an improved organization and for the

enlargement of the scope and content of the service at present provided by the State, these changes could be achieved without any violent break with the traditional basis of medical practice. The defects are defects in the present system, not of it. It is not necessary to introduce a whole-time salaried medical service to achieve the reforms which supporters of that method maintain are necessary. The quality of individual service would not necessarily be improved by the replacement of a variable income by a fixed income or by the substitution of the State for the individual in the selection and employment of a doctor. Team work, correlation and co-ordination, easier opportunities for regular post-graduate study, pension schemes, and freedom from financial worry could be achieved without recourse to a whole-time salaried service administered by the State.

48. The majority view is that it is essential to bear in mind the fact that we could not, if we would, start with a clean slate. There have grown up in recent years types of medical service which, although unrelated and uncoordinated, are efficient within their own fields, and cannot lightly be discarded or ignored. What is wanted is the adaptation, augmentation, and reorientation of existing services so as to integrate them into a co-ordinated whole. National Health Insurance has proved a greater success than was anticipated either by its supporters or by its opponents. To-day it is an integral part of the social structure. Its medical service contains features which have proved to be essentially sound, such as free choice of doctor, the minimum of interference by the State, and the central negotiation of terms and conditions of service. Whether it remains contributory or not is a matter for the community as a whole to decide. But that its essential features should be embodied in any national medical service is the opinion of the majority.

49. The majority view having been ascertained, the next step is to work out a scheme for co-operative general practice in health centres which is envisaged as ultimately the main agency for non-institutional personal health services in an ordered and comprehensive medical service. There are, however, certain radical alterations in administration, the acceptance of which is regarded as an essential condition to the full adoption of proposals for co-operative medical practice.

#### PROPOSALS. Administration.

50. This group of proposals is set out first as it is regarded as fundamental to the whole plan. Unless and until the main features of the structural changes find expression in legislative action, the other reforms here recommended will be denied the foundation they need. This is not to say that considerable progress cannot be achieved in a comparatively short time by interim measures.

#### *Central Administration.*

51. A central authority should be established to be concerned solely with all the civilian medical and auxiliary services of the country. This authority may be a Government Department in the usual sense or it may be a corporate body formed under Government auspices and responsible through a Minister to Parliament. It should have a medical practitioner as its chief officer. It should deal with civilian medical and ancillary health services, including general practitioner, hospital, and public health services, industrial health services, and the medical treatment of pensioners. These proposals for the establishment of a central authority extend to Scotland as a separate national unit.

52. If the departmental method is adopted there should be established either a Central Medical Advisory Committee to advise the Minister, or a Central Medical Services Board with both advisory and executive functions. If the former proposal is adopted the Central Medical Advisory Committee should have a statutory basis and should meet regularly to advise the Minister on medical matters within the scope of his functions, but not including those matters which properly fall to be dealt with by negotiation between the Minister and the organized body of the profession, such as the terms and conditions of

service. The chief officer of the Minister should attend the meetings of this Central Medical Advisory Committee and take part in its discussions. The alternative is a Central Medical Services Board which is predominantly medical in its composition. In addition to advising the Minister it would have executive functions in regard to the entry of the profession into the public medical service, disciplinary machinery, superannuation arrangements, and possibly postgraduate and refresher course arrangements. Whichever method is adopted a similar arrangement should be made in relation to the Scottish central authority.

53. If the method of the corporate body is followed, the controlling body should be executive in character, responsible only on matters of major policy to a Minister, and predominantly medical in composition.

54. The central health authority would be responsible for the formulation and administration of national health policy and the terms and conditions of service, which would be national in their operation. It should control and administer the funds provided by the Government for medical services. The money available for medical services should be maintained as a separate fund to be devoted wholly to these services.

#### *Local Administration.*

55. The local administrative body would be concerned with administration within the framework of the policy laid down at the centre. It is important to emphasize that the formulation of policy should be the responsibility of the central authority. The local authority should be purely administrative.

56. The system under which local authorities administer in detail a broad national policy decided by the central Government is deeply embedded in the social fabric of this country. There is, however, general agreement that many of the existing local units are too small or too poor, or both, to administer such services efficiently. The efficiency of hospital, medical, and allied services, including the environmental and personal health services, as well as their co-ordination with other local government services, could be secured by the creation for all local government purposes of elected authorities for new areas with populations much larger than those of most of the existing major local authorities. The extent of such new areas should depend partly upon lines of communication to and from convenient centres, and partly upon areas having populations large enough to justify self-contained services which are both comprehensive and well balanced. The population of such areas should as a rule be not less than 500,000.

57. But size of itself is not enough. Such new local authorities, hereafter called Regional Authorities, should be required by statute to delegate the administration of hospital and other medical, health, and allied health services to a committee or committees, containing non-elected members with knowledge and experience of such matters, including an adequate representation of the medical profession. In relation to each Regional Authority there should be established by statute an Advisory Medical Committee which should meet regularly and advise the authority on medical matters. The chief medical officer of the area should attend meetings of this regional Medical Advisory Committee and take part in the discussions.

58. An alternative is the compulsory establishment by legislation of Regional Councils, representative of the local authority or authorities in the region and including nominees of the central authority, representatives of voluntary hospitals, and an adequate representation of the medical profession. These councils would assume the responsibility for the local administration of health services. They would have executive powers and a certain measure of financial control, and they would have direct access to the central authority. On any subsidiary committees established there would be an appropriate representation of the medical profession or voluntary hospitals, or both. The medical advisory arrangements set out above would obtain. Under this proposal, even if the boundaries of local authorities were in fact modified so as to make their areas suitable regions for the purposes of hospital

and personal health services, there would still be a need for a regional council which would have the right to report direct to the central authority.

59. The general principles for local administration submitted in the foregoing paragraphs extend to Scotland as a separate national unit.

60. It is recognized that it will be necessary to amend the existing law in order to permit medical practitioners to act as members of local authorities while participating in the medical services outlined in these proposals.

#### Group Medicine and Health Centres.

61. Some of the difficulties that beset the general practitioner to-day arise from the rapid advance of medical science and the increasing complexity of medical practice. Others are due to the isolation of the general practitioner from consultant and specialist services, from hospital services, from public health services, from administration, and from his own colleagues; to the failure of public authorities adequately to recognize the value of the general practitioner; and to the continuance of traditional individualism into an age where division of labour and co-operation are essential factors in social service.

62. At the present time, the single-handed practice or partnership is usually conducted from a doctor's private residence. Certain rooms are used for professional purposes, and personal or borrowed capital is invested in equipping the practice with apparatus and in keeping it up to date; additional domestic staff is employed to keep the surgery and waiting rooms clean and to deal with callers; the secretarial work and record-keeping are done by the doctor himself or a secretary employed for the purpose; dispensing, if done at the surgery, is undertaken either by the doctor or a dispenser employed by him. This arrangement is repeated many times over in a fairly well populated district.

63. Greater efficiency and economy would be secured and less expense incurred if groups of practitioners would co-operate to conduct a single centre at which all of them would see their own patients and share equipment and the services of secretarial, domestic, and dispensing staff. The value of the practitioner to his patients would gain immeasurably from his close and constant contact with his colleagues.

64. Group or co-operative general practice is desirable, though some variation of the organization would be necessary in sparsely populated areas. In the following paragraphs a scheme for group practice is outlined which it is believed would be workable in many areas and which would go far to meet the defects of the present system.

65. Before setting out the model scheme reference may be made to a number of proposals already put forward for "health centres". In these schemes there is much divergence of opinion on the nature, scope, and functions of a health centre. In the Interim Report of the Consultative Council on Medical and Allied Services, 1920, a scheme of primary and secondary health centres was outlined, the primary health centre being "an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of the district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists". The report suggests that accommodation should include wards for various purposes, an operating room, radiography rooms, a laboratory for simple investigations, and a dispensary.

66. The health centre scheme of supporters of a whole-time salaried medical service involves the conception of a health unit in which the health centres would be linked with the hospitals, assume the duties of certain special clinics, co-operate in matters of public health, and ensure for all a complete domiciliary consultant and institutional service.

67. Another scheme of group medicine envisages a group of general practitioners working together at a local centre rented or owned by them. The accommodation at the centre would include consulting and waiting rooms, a pathological room, a theatre for minor surgery, and possibly a small X-ray department. The staff would consist

of principals, who would receive remuneration on a capitation basis with a percentage bonus for experience and special qualifications, and probationers paid by fixed salary. The financial and medical arrangements would be in the hands of a medical committee consisting of all the principals.

68. A third proposal advises the continuance of the partnership system in a health centre plan, the centre being regarded simply as a communal partnership surgery. The receipts would be pooled and the net income shared as in a partnership.

69. In the preparation of the following model scheme the essential factor has been borne in mind that, while the health centre must on the one hand preserve the professional independence of the co-operating general practitioners, it must on the other hand be capable of becoming an organized unit in an integrated medical service. The alternative lies between a voluntary co-operative enterprise, organized and administered privately by the co-operating practitioners, and a health centre which would be provided by a statutory health authority and would constitute an officially recognized unit in a comprehensive service administered by that authority. The defects and difficulties arising out of the optional character of the voluntary arrangement lead to the choice of the statutory scheme, which would secure rather than merely invite the integration of personal and preventive services. In some areas practitioners may wish to anticipate a statutory scheme and establish health centres by voluntary co-operation. Such experimental centres would demonstrate the value of co-operative practice and would prepare the way for, or might even render unnecessary, the local adoption of a statutory scheme. In any case, the introduction of a national statutory scheme must proceed gradually, area by area, in the light of geographical and other local conditions.

#### Model Health Centre.

The paragraphs that follow contain suggestions for a standard form of health centre that may be adapted to suit local conditions.

*Provision of Centre.*—The health centre being an official part of a regional authority's comprehensive medical service, the building and equipment would be provided or approved by that authority.

*Clients.*—It is recommended that a State scheme of medical service should be provided for all persons with incomes within the current National Health Insurance limits and for their dependants, in effect for about 90% of the population. The general medical care of these persons would be undertaken by general practitioners of their choice either at the centre or in their own homes. Persons outside the scheme would attend at the centre or at the practitioner's private residence or would be visited in their own homes as mutually arranged.

*Service Available.*—General practitioners would attend at the centre at hours convenient for their patients and would pay domiciliary visits from the centre. They would undertake ante-natal, natal, and post-natal work; they would take part in infant and child welfare and the school medical service; they would arrange consultations with specialists, some of whom might attend at the centre; and they would be associated with the local hospitals. The work of the centre would be preventive and educational, as well as curative. Midwifery, nursing, and auxiliary services would be available at or through the centre, midwives, health visitors, and district nurses working from the centre. The centre should have ready access to an X-ray and a pathological department at the centre or elsewhere, these departments being under proper specialist supervision. Dispensing might continue on the present National Health Insurance lines or be arranged at the centre, but in any case a dispensary service for drugs, etc., required by the practitioner for immediate application would be conducted at the centre. A communal service would be maintained for record-keeping and secretarial work.

*Accommodation.*—The accommodation could include:

- (1) A consulting room for each doctor working at the

centre at any one time. (ii) Waiting rooms. There might be several moderate-sized waiting rooms, which would be used in common and not allocated to particular practitioners. (iii) A small theatre for minor surgery within the competence of a general practitioner. (iv) A small X-ray department. (v) A pathological room for simple diagnostic investigation. There would be accommodation for a resident caretaker and for secretarial work and records.

**Size and Area.**—The area covered by the centre would not be too large, partly in order that patients should not be required to travel far. The number of practitioners co-operating to provide the service would depend upon the size and nature of the area served, but it would normally be from 10 to 12 in urban areas and 6 to 8 in mixed areas.

**Free Choice.**—The citizen would be allowed to choose his health centre within a reasonable distance and he would select a doctor from those working at the centre. The doctor would have the right to reject a patient he did not wish to attend. He would work at one centre only.

**Medical Staff.**—The medical staff would consist of a number of principals and assistants. Each principal would have his own list of persons who select him. The principals would attend at the centre at arranged hours just as they now hold surgeries at their private residences, they would attend patients in their homes, consult with specialists, take part in hospital work, and hold sessions for "public health" duties, such as the treatment of school children. Hours of duty would be arranged so that normally each principal would have a reasonable amount of leisure. Periods for holidays and for compulsory regular postgraduate study would also be arranged. A rota would be prepared so that one doctor was always available for night calls or emergencies during the day. At each centre there would be a number of assistants, normally junior practitioners gaining experience. The assistants would be appointed to the centre and not to an individual principal. Their work would be decided by the committee of principals, but in general they would help and deputize for the principals. It is estimated that in a centre staffed by 12 doctors at least one would be an assistant.

**Local Authority Services.**—The medical staff as a whole would assume responsibility for the ante-natal, post-natal, infant welfare, and school medical work which is at present rendered by the medical staff of local authorities. This work, like all other work within the competence of the general practitioner, would be within the "contract" of the practitioner appointed to the service. A practitioner undertaking midwifery cases would undertake the ante-natal and post-natal work of his own patients in association with the midwife. Delivery would take place in the home or in a maternity home. Where normal cases were attended by the midwife, the doctor would remain available in case of need. Abnormal cases, in the ante-natal, natal, or post-natal phases, would be referred to a specialist or admitted to hospital. The operational headquarters of the midwives would be the health centre. The infant welfare work would be organized on educational and preventive lines, as at present. Health visitors and district nurses, like midwives, would be based on the centre, and they would assist in all the work of the centre. Medical treatment of school children, including the treatment of minor ailments, would be undertaken at the centre probably by one or two members of the centre staff, aided by school nurses or health visitors. Immunization would also be carried out at the centre. Work in tuberculosis, venereal diseases, mental deficiency, orthopaedics, child guidance, and in other such specialized branches would not be undertaken at the centre or by the centre staff, but at special clinics with specialist staffs.

**Conditions of Service of Medical Staff.**—The terms and conditions of service for both principals and assistants in respect of persons covered by the scheme would be on a nationally agreed basis. A condition would be made that terms of service should not be altered without full and proper consultation with the organized medical profession. Remuneration would be paid directly from public funds, and the sale and purchase of practices by practitioners

within the scheme would cease. The terms would include provision for superannuation, dependants' pensions, and disablement allowances.

**Entry to Service.**—As soon as local conditions, including the provision of centres, permit, existing practitioners would be invited to form themselves into groups to provide a nucleus for a health centre service. They would be offered compensation for loss of capital in the form of guaranteed non-contributory retirement and death pensions. Practitioners over the maximum age would be able to translate the capital value of their practices into an annuity without actually working at the centre. In areas where no health centres were formed practitioners would be given an opportunity to commute their practices into pensions. In the case of practitioners who retained a certain amount of private practice the value of such practice would be taken into consideration in assessing the amount of compensation. When existing practitioners were absorbed vacancies would be advertised and new appointments would be made to the service by or on the authority of the regional authority after consultation with the medical committee of the centre concerned. In making appointments preference would be given so far as possible to the entrant's choice of centre, subject to the existence of a vacancy in the establishment.

**Assistants.**—A practitioner appointed as assistant would hold that post for a specified period and would receive a salary according to a scale. At the end of that period he would be entitled, subject to satisfactory service, to promotion to principal in either the same or another centre.

**Principals.**—The remuneration of a principal would consist of three parts: (a) A basic salary with special additions for special qualifications and length of service; (b) a capitation fee related to the number of persons or families on his list; (c) any fees received in respect of services not covered by the capitation fee, whether undertaken at the centre or not, and any salary received for work outside the scope of the service.

**Principals' Lists.**—A principal would accept patients for his list up to a prescribed maximum number. When a principal's post became vacant and a new appointment was made, the persons on the list of the retiring or deceased principal would be invited to choose a new doctor from among all the principals, including the newly appointed principal; they would be requested to make a definite choice. In this way the new principal would probably begin a list of his own.

**Administration.**—As an organized unit of medical service the centre should be provided with proper arrangements for internal administration. For this purpose the principals should form themselves into a committee, elect a chairman, and meet regularly to consider all matters affecting the conduct of the centre. These will include questions of internal organization, admission of principals, appointment of assistants, the consideration of complaints and disputes, questions affecting the visits of consultants and specialists, the acceptance by principals of outside appointments, and the relations of the centre with local or regional authorities, hospitals, and other bodies. It might be advisable to elect one principal to act as medical superintendent of the centre for the purpose of exercising general supervision over the day-to-day work. Some payment should be made to the practitioner for these duties.

#### Rural Areas.

70. The form of health centre suggested above is primarily applicable to urban and mixed areas, but its principles are also applicable, with suitable variations, to rural areas. The health centre in a sparsely populated rural area would in fact be a one-man centre and the centre would probably be located at the practitioner's residence. He would have the same advantages as his urban colleagues in association with public health services and hospital and consultant services, in assistance with equipment, and in participation in pensions, postgraduate courses, and similar organized facilities. The rural practitioner, however, needs something more. He needs not so much a common centre for practice as a diagnostic centre where pathological and

other investigations could be made locally without reference to a hospital. He also needs a consultation centre: for example, an arrangement by which consultants in different branches of medicine would come to the area periodically to hold sessions to see patients presented by the practitioners. Under the co-ordinated scheme of medical services contemplated such facilities would be organized for the rural practitioner. If the main proposals are accepted by the profession a full investigation can then be made of the needs of rural practitioners and the best means of satisfying those needs.

#### Immediate Proposals.

71. The proposals for health centres are put forward on the assumption that the administrative changes recommended will be implemented before the establishment of official health centres. If such administrative changes are to be long delayed, the majority feel that in the meantime steps should be taken to make available to insured persons and their dependants the medical benefits now available under National Health Insurance, augmented, if possible, by a consultant, specialist, and laboratory benefit. The adoption of this proposal, which is elaborated much more fully in the British Medical Association's Proposals for a General Medical Service for the Nation, would not prejudice the ultimate adoption of the whole scheme but would go a long way to satisfy an urgent public need in the intervening period, which, for a variety of reasons, may be protracted. The extended National Health Insurance Service would during this interim period be locally administered as at present by insurance committees.

72. It is recognized that such a development would not of itself secure the unification of health services, either centrally or locally. It would, on the other hand, make available to a large section of the community a medical service which at present it finds difficulty in securing. The present generation should not be denied a more adequate medical service because of the time, the difficulty, and the controversy that may delay the administrative changes upon which co-ordination and integration mainly depend.

73. Further, there is no reason why in any intervening period experimental health centres should not be established by voluntary co-operation. The experience gained would be invaluable in demonstrating the advantages of group practice and in bringing to light pitfalls to be avoided in any statutory scheme.

#### Hospital and Specialist Services.

74. The unit of hospital administration should be the region. The nature of the regional body will depend upon which of the alternatives mentioned in paras. 57 and 58 is adopted. If the method of Regional Councils described in para. 58 is adopted the hospital services would be administered by the Regional Council, whose membership would include nominees of the central authority and representatives of the local authorities, the voluntary hospitals, and the medical profession in the area. If new local authorities, to be known as Regional Authorities, are formed, as described in para. 57, the administration of hospital services would be statutorily delegated to a special committee of the Regional Authority, upon which would be represented the voluntary hospitals and the medical profession.

75. In a regional scheme all hospital provision and the higher administration of the hospital services would be the province of the Regional Council or Authority. The latter would not interfere with the internal organization of individual hospitals, but the general conditions in all the hospitals should be similar. It is undesirable that in a unified scheme the important differences that prevail to-day between voluntary and council hospitals should persist.

#### Admission of Patients.

76. In the matter of the admission of patients, for example, the conditions prevailing in voluntary hospitals are radically different from those in council hospitals. The general wards of the voluntary hospitals are open only to those persons who cannot afford to obtain privately the specialist institutional service they need. In practice this

means an income limit applied with discretion. Persons with incomes above this limit are admitted to pay-beds or nursing homes and the specialist is paid a private fee. Council hospitals administered under the Public Health Acts, on the other hand, are open, without income limit, to all the inhabitants of the area they serve, and the patient pays according to his capacity up to the maximum of the average daily cost to the local authority. In cases where the local authority provides pay-beds the specialist treating a patient in a pay-bed cannot receive a fee commensurate with the patient's capacity to pay because the hospital charges are based on the average daily cost and this does not include direct fees for professional services. It is felt by many persons that this difference of method should disappear, even though its removal should involve an alteration of the law.

77. A frequent complaint is that the voluntary hospitals select the cases they will admit and cannot be compelled to admit a patient. On the other hand, where a local authority makes provision for general hospitals, accommodation must be made available for any person in its area. The result is that often the council hospitals receive a relatively small proportion of the most interesting clinical conditions, and this deprives their medical staffs of a certain amount of professional opportunity. In the case of hospitals engaged in the teaching of medical students some selection of patients is necessary, but in other cases it should be possible in a regional scheme to ensure that the system of admission to all hospitals is uniform and strictly in accordance with medical needs and the facilities available.

#### Medical Staffing: Clinical Career.

78. In the present conditions of hospital practice a man who wishes to devote his life to a career in some branch of clinical medicine finds many obstacles in his path. It is true, on the whole, that in the voluntary hospitals he has the opportunity of developing his particular interest, but at the same time the fact that he receives little or no remuneration for his services to the hospital sometimes makes it impossible for him to apply the requisite initiative and energy to his hospital work, for he must also develop an adequately remunerative private practice. He may also find hindrances to promotion in the system of "in-breeding", in the tendency to automatic promotion from lower to higher posts, or in his inability to spend some time in work in other hospitals or in visiting foreign countries for fear of losing a chance of promotion in his own hospital.

79. In the council general hospitals the system of organization is not so conducive to a clinical career. Here, as a general rule, the posts carrying the highest salaries are mainly administrative. Consequently, when a man reaches a certain stage he must choose whether to continue in clinical medicine, for which he has been trained, and be content with a lower salary, or to aim at the administrative posts, for which he may or may not be suitable, and obtain a higher salary. The fact that this choice has to be made is of great significance. It tends to discourage the man who is keen on his professional work from entering those council hospital services where whole-time higher clinical posts are not available, and also to deprive the council hospitals of the professional services of physicians and surgeons just at the time when their medical experience is becoming mature.

80. In view of these considerations it is desirable that in the hospitals in a regional service there should be available higher clinical posts carrying salaries and status no less than those of administrative posts. In other words, there should be separate ladders of promotion for clinical and administrative posts. A man would then be able to enter the regional hospital service with the assurance that, whatever type of hospital he served, he could pursue the career that most appealed to him.

#### Types of Appointment.

81. It will be the duty of the Regional Council or Authority to ensure that every hospital in its area is suitably and adequately staffed. There is general agreement that the system at present obtaining in the larger voluntary hospitals, in which appointments up to and including

those of registrar and chief assistant status are whole-time, is satisfactory. Several schemes have been put forward for the organization of the more senior members of the staff, but since all systems of hospital staffing have disadvantages as well as advantages, it is undesirable to advocate any single system for general application throughout the country or throughout a region. There are, however, certain general principles which should be observed. For example, there should be no distinction in the method of staffing between voluntary and council hospitals. There should be no separation of the out-patient and the in-patient work; a practitioner holding an appointment at the hospital should be concerned with both types of work throughout his hospital career.

82. There are three main types of appointment. A post may be a whole-time salaried one without any right to practise for gain. Such appointments would include a certain number of clinical chairs which offered the professor a purely academic career in medicine, and a number of senior posts which offered a definite career as a whole-time officer. The number of appointments in this group need not be large, for it is generally believed that the right to some private practice is to the advantage of the community, the individual officer, the hospital unit, and the profession.

83. The second type of appointment is a whole-time salaried post with the right to undertake a certain amount of private practice within the hospital. This type is suitable for the head of a clinic or department in certain branches of medicine or surgery in which most of the patients are able to travel to seek advice. It is desirable that he should be allowed to give consultations and render treatment in the private wards of the hospital and to receive a fee for his services, provided that his primary function as the head of a clinic remains the general service of the hospital, the teaching of medicine, and the pursuit of research.

84. The third type of post is the part-time salaried appointment with freedom to undertake private practice either within or outside the hospital. In the view of the majority part-time service with reasonable remuneration should be developed as a feature of the post-war hospital and consultant service. The part-time officer would be responsible for the care and supervision of his hospital patients and for other hospital service, and for the remainder of his time he would be free to engage in private practice. The term "hospital service" here comprises not only work for in-patients and out-patients but also domiciliary visiting, for it is contemplated that the consultant and specialist service to be provided by the State for persons within the income limit of £420 a year would be based on the hospitals and organized regionally.

#### *Consultant Services for the Smaller Hospitals.*

85. Part-time salaried appointments in a regional hospital scheme may also prove the solution to the problem of providing fully qualified consultant staffs for the smaller hospitals. There are groups of small hospitals in areas containing a number of small towns which may be 50 miles or more from a key hospital. The civilian population in these areas has no easy access to consultant and specialist services, and the hospitals are staffed by general practitioners who may have to undertake work beyond their training or competence. It is desirable that certain consultant specialists should be appointed to such a group of hospitals and should be regarded as members of the regional staff rather than as members of the staff of particular hospitals. The plan has many advantages. It would help to co-ordinate the small hospitals with each other and with the key hospital; it would raise the standard of hospital practice, including the standard of record-keeping; and it would increase the confidence of the public in their local medical services.

#### *Remuneration.*

86. All members of hospital staffs should be adequately remunerated for all services rendered to hospital patients. A national minimum scale of remuneration for hospital staffs, both whole-time and part-time, should be established

for the guidance of bodies making appointments. It is emphasized that when grants of public money are made to voluntary hospitals they should be sufficient to permit the payment of salaries on this scale. The method of remuneration of consultants and specialists attending patients under a State scheme is considered below.

#### *Selection of Staff.*

87. The success of any hospital system must ultimately depend upon the efficiency of its medical staff, and for this reason the method of making appointments to the staff is of fundamental importance. Unless the appointing body is both disinterested and competent to assess professional efficiency there is a danger that unsuitable appointments may be made. The selection of consultants and specialists for appointment to the staff of hospitals, or groups of hospitals, in the region or to the region as a whole should be made on the advice of a medical appointments panel specially appointed by the Regional Council or Authority. The panel should include representatives of the university or universities in the region and, for certain senior appointments, assessors from outside the region.

#### *Field of Experience.*

88. It is desirable in the interests of efficiency that a practitioner adopting a career in the hospital service should be given opportunities for widening his experience as much as possible. If he so desires and suitable arrangements can be made, he should be permitted to leave his own hospital for a period and take a temporary appointment in another hospital or visit hospitals in other countries. Such absence should not prejudice his career in his own hospital.

#### *Medical Committees.*

89. A difference of fundamental importance that exists between voluntary and council hospitals lies in the internal medical administration. In the voluntary hospitals a medical staff committee is given full scope for initiative and responsibility in all internal affairs of a professional character. In clinical matters its authority is complete. In the council hospitals, on the other hand, too much of the responsibility for internal administration is vested in the medical superintendent and too little is allowed to the other members of the medical staff. The medical staff has not access to the hospital committee of the authority except through the medical superintendent. The lack or insufficiency of executive responsibility may hamper the medical staff in the work of their departments and may retard medical progress. There should be, therefore, in all hospitals medical committees composed of the medical staffs above a certain grade, and these committees should have direct access to the hospital committee of the authority or to the management of the hospital, as the case may be.

#### *Contributory Schemes.*

90. The Government has stated its intention of maintaining the principle that, in general, patients should be called on to make a reasonable payment towards the cost of hospital benefit, whether through contributory schemes or otherwise. Regional contributory schemes of uniform pattern providing benefit at any hospital should be developed, and the principle of inter-availability of benefit throughout the country should be encouraged. There is a definite therapeutic as well as a financial value in an arrangement which overcomes the necessity for paying a lump sum for medical treatment at the time of illness or immediately afterwards. For persons above contributory scheme limits there should be insurance provision of a provident character, with "full cover" for those within specified limits and possibly only "grant in aid" for those above these limits.

#### *Teaching Hospitals.*

91. Any scheme for the division of the country into regions for the purpose of hospital administration should provide so far as is practicable for the inclusion of a teaching hospital in each region. In the constitution of the Regional Council or Authority provision should be made for the representation of the university in the area, or, if there is no university, of the parent university with

which the teaching school is associated. It is recommended that the clinical teaching of students should be undertaken so far as is practicable in the hospital of the medical school and in association with other special and municipal hospitals and health services in close proximity to the school.

92. It is very desirable that university standards should permeate all medical teaching and research, and that the formation of university units should be encouraged. The number of university chairs in clinical subjects should be increased and the appointments should be made by the university. The remuneration should be by salary. It would be advisable that in some of these appointments the holder should not be permitted to practise for gain either in the hospital or outside it, in order to provide posts offering a purely academic career.

93. The higher-paid teaching staffs should be appointed on the recommendation of an advisory appointments board on which the university is adequately represented. All clinical teachers should receive salaries for their services as teachers. Practitioners on the staffs of teaching hospitals should be remunerated for their general hospital work.

94. It would be an advantage to both the community and the practitioner if, when the medical student has passed his final examination, he could spend some time in practice under supervision before he embarked in practice on his own account. It is suggested that the student should be registered provisionally when he has passed his final examination, and that he should then be required to practise under supervision in some approved hospital or health service. The period of such practice should be one year, at least half of which should be spent in one hospital. At the end of the period, provided that his work satisfied the appropriate authority, he should be allowed to complete his registration.

#### *Immediate Proposals.*

95. Hospital reorganization cannot await the reform of local government areas and functions if, as is expected, that reform will involve considerable delay. Some proposals for immediate reform are therefore put forward.

96. Whether the method of Regional Authorities (para. 57) or of Regional Councils (para. 58) is ultimately adopted, there should be established as early as possible in each natural hospital area a Regional Hospitals Council, which should be statutory and should include in its membership nominees of the central authority, the major local authorities, and the voluntary hospitals, and an adequate representation of the medical profession in the region. Such Regional Hospitals Councils should have headquarters with suitable office staffs, and their functions should include the responsibility of considering, co-ordinating, and formulating schemes for hospital services in the region, and they should advise what part each agency should take. In relation to each Regional Hospitals Council there should be a Medical Advisory Committee appointed by the medical profession in the area. To this Medical Advisory Committee all professional problems would be referred for observation and advice before a decision on them was given by the Regional Hospitals Council.

97. It may be found in forming these hospital areas that the area of an existing local authority provides a suitable region for hospital administration. Even if this be so, there should still be established for the area a Regional Hospitals Council, as described in the preceding paragraph, on which the local authority should be represented.

98. Opinion differs on the question of the powers to be invested in the Regional Hospitals Councils. One view is that they should be executive and should have access to funds. The other is that they should be advisory only. The supporters of the latter view maintain that to remove from local authorities the executive responsibility for the hospital services at present administered by them would result in the disintegration of local authority medical services and would create more difficulties than it would solve. They urge that if the advice of an advisory Regional Hospitals Council went unheeded by hospital authorities, the central authority could impose its views by, for example, withholding grants or refusing approval to schemes of development.

99. Those who consider that the Regional Hospitals Council should have executive powers maintain that if the council is to formulate major hospital policy, to plan the situation and accommodation of hospitals of various types in its area, and to co-ordinate hospital services generally, it must possess the means of exercising effective supervision over the way in which the different agents provide their services under its aegis. It must have power to enforce its decisions or else its efforts will be stultified. This would not involve interference by the Regional Hospitals Council with the internal organization of individual hospitals, though advice might be offered. Its executive functions should, it is argued, be conferred for the purpose of enabling it to ensure that each agency or section does in fact carry out efficiently the part allotted to it in the plans made in the region as a whole. In short, the conferment on the Regional Hospitals Council of executive power and a certain amount of financial control would seem to the supporters of this view to be the only means of securing an efficient system in the region as a whole.

#### *Specialist and Consultant Practice.*

100. Some reorientation of consultant practice will be necessitated by the restriction of the present field of practice as a result of changing economic conditions and the creation of a State-provided consultant service for a large proportion of the population. It may be expected that there will be in the future an increased amount of consultative work among "scheme" patients outside the hospital, and provision must be made for it.

101. The specialist and consultant services to be made available to all persons within the prescribed income limits should be administered on a regional basis as an integral part of the complete regional scheme of hospital and personal health services. Consultations would ordinarily be given at the hospital, in the patient's home, or at a health centre as required. The service would be based on the hospitals, which would be given the specific duty of providing a non-hospital as well as a hospital service of consultants and specialists. The services of a consultant would normally be obtained through the agency of the family doctor.

#### *Conditions of Service.*

102. The possible methods for the remuneration of consultants and specialists are: (a) a fee for each item of service rendered; (b) a sessional fee; (c) a salary. The general opinion is in favour of payment by salary, a method which conforms naturally with the view that the consultant service should be based on the hospital. It is necessary in the interests of efficiency that a consultant should be attached to a hospital so that he may keep in close and constant touch with hospital work and the progress of his specialty. It is considered desirable that in-patient work and out-patient work should not be rigidly separated in hospital practice; a member of a hospital staff should be concerned with both types of work throughout his hospital career. Most consultants in the scheme would take part in both, and many would also visit patients outside the hospital. All this work should be included in a single salaried contract of service, arranged through the Regional Authority in accordance with a national standard.

103. Remuneration by salary does not imply that all appointments would be whole-time. Many of them would be part-time, and the amount of time to be devoted to the service would be determined by the particular contract. The specialist staff of a key hospital would consist of a few whole-time members who remained in the hospital and did no private practice, some members who remained in the hospital and were allowed private practice within its walls, and others who did a certain amount of work at the hospital and spent some time in domiciliary or health centre work or in visiting smaller hospitals. The salary paid would be inclusive for all work done for patients within the scheme.

104. A consultant accepting a part-time appointment under the scheme would be required to devote a prescribed period of time to the work of the scheme. Outside the terms of this contract he would be permitted to attend

privately persons outside the scheme and to accept fees for his services to them.

#### *Free Choice.*

105. Within the hospital region as large a measure of free choice of consultants as possible should be allowed to the practitioner. The principle of free choice must, however, be adjusted to the proper performance by consultants of their hospital duties.

#### *Consultant Status.*

106. One of the difficulties for both consultants and general practitioners in the present medical services is that there are no generally accepted standards which confer consultant status upon a practitioner. The qualifications and standards of consultant and specialist status should be considered and determined by a recognized central body of academic character. One suggestion is that this body should be, for England and Wales, a committee set up by the three Royal Colleges, and for Scotland a committee set up by the three Royal Scottish Corporations, and the Royal College of Obstetricians and Gynaecologists. There should be provision for liaison between the two bodies. These committees would determine the nature of the requisite qualifications, but one of the essentials should be that the applicant should hold, or have held, a recognized hospital appointment in the specialty concerned.

#### *Immediate Proposals.*

107. The proposals for consultant and specialist practice, like those for general practitioner and hospital services, can be put into operation only when the basic administrative reforms have been secured. As an immediate step the majority consider that non-institutional consultant, specialist, and laboratory services should be made available as part of an extended National Health Service, as outlined in the British Medical Association's Proposals for a General Medical Service. It is probable that the method of remunerating consultants during this period will have to be on an "item of service" basis.

#### *Matters for Further Consideration.*

108. It will be appreciated that this interim report has been concerned primarily with broad general principles. There are many other important questions, to some of which a brief reference has been made, which will need full consideration by the Commission when the profession has expressed its opinion on the present report.

#### *Industrial Health.*

109. The problem of industrial health, however, demands a special reference. At the present time the whole of the country's effort is directed to the development of adequate and efficient fighting and defence services. This effort largely depends on production by industry and the output of the individual worker. Conservation of health in industry, therefore, is one of the most important immediate problems before the medical profession, and an urgent issue is to ensure that its contribution is made in the best possible way. The Commission feels that the contribution is not necessarily limited to those doctors already employed in industrial medical practice, but embraces all branches of the profession, and in particular the general practitioner and hospital services of the country.

110. So far as the future of industrial medical practice is concerned the Commission offers no detailed proposals at this stage, because the method of development of this new branch of medicine will depend very largely on the general health policy that the country adopts. It recognizes, however, the importance of its development and its essential place in any scheme for improved national health services, and for that reason it will form the subject of subsequent report.

#### *QUESTIONS FOR DECISION.*

111. In order to focus attention on the major points of principle set out in this report, and in order to facilitate the later work of the Commission in adapting this docu-

ment to bring it into conformity with the views of the profession as a whole, there are set out below the main important questions upon which decisions should be reached. The list is not exhaustive, but it does, it is believed, cover most of the ground.

1. Is the broad definition of the objects of medical service accepted?

(a) To provide a system of medical service directed towards the achievement of positive health, the prevention of disease, and the relief of sickness;

(b) To render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional.

2. Should free choice of doctor and patient be an essential feature of any future service?

3. Should group practice be a feature of any future medical service?

4. Should provision, whatever its character, be made by Government for the whole community or for a part of it only? If the latter, to which section of the community should it be limited?

5. Should the basis of the co-ordination and integration of health services implied under 1 (a) above be:

(a) The extension of the type of medical benefit available under National Health Insurance to the dependants of wage earners and others of like economic status coupled with the enlargement of its scope by the inclusion of consultant and specialist services; or

(b) The establishment of a whole-time salaried Government medical service; or

(c) Some other method?

6. If some other method (5 (c)) is favoured, should the plan set out in broad outline in this document be accepted in its present or an amended form? It involves ultimately:

(i) Changes in central machinery;

(ii) Changes in local machinery, either (a) by the creation of new elected local authorities; or (b) by the establishment of Regional Councils, representative of the local authority or authorities, the voluntary hospitals, and the medical profession;

(iii) Medical advisory machinery, both central and local;

(iv) The establishment of health centres either by the Government or in some other way;

(v) The concentration of general medical work, both preventive and curative, in health centres;

(vi) The unification of hospitals under a regional body;

(vii) The appointment of practitioners to a national service;

(viii) The remuneration of general practitioners on a part-time salaried basis with a variable element in proportion to the number of persons or families choosing them, provision of pensions on retirement, and on death for dependants;

(ix) The remuneration of consultants on a salaried basis;

(x) Compensation for loss of capital;

(xi) The gradual disappearance of the custom of buying and selling practices.

The plan is devised on the assumption that the service would be available to those within the current income limits of National Health Insurance, whether earners or dependants. If this plan is accepted in broad outline, what, if any, are the modifications and/or amendments proposed?

7. In view of the fact that the full adoption of the plan may be delayed for various reasons, should some interim changes be made? If so, are the proposals for immediate post-war application acceptable, viz.:

(i) The two-way extension of National Health Insurance to include (a) the dependants of wage-earners and others of like economic status within the current National Health Insurance income limits, and (b) the provision of consultant and specialist services;

(ii) The establishment of experimental co-operative practice in some areas;

(iii) The creation of Regional Hospitals Councils with executive or advisory functions?

## The Medical Journal of Australia

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### THE FUTURE OF MEDICINE: A REPORT FROM ENGLAND.

In its discussions during the last few months on the future of medicine in Australia and on the provision of a general medical service that will meet the growing needs of the Australian people, the medical profession has in the opinion of many been handicapped by its failure to receive even one copy of the Draft Interim Report of the Medical Planning Commission, published in the *British Medical Journal* of June 20, 1942. Copies of that journal failed to reach Australia as a result of enemy action. Realizing that even when some copies of the missing journal did arrive in this country, they would reach very few of the members of the British Medical Association in Australia, we cabled to London for permission to reprint the report in THE MEDICAL JOURNAL OF AUSTRALIA. The Editor of the *British Medical Journal* has generously given permission and the report is published in the present issue. During the last few weeks a good deal of space has been taken up in this journal by reports of evidence given in Melbourne and Sydney before the Parliamentary Joint Committee on Social Security. No attempt has been made to record all the evidence given before this committee. The evidence was published, not so much to give the views of certain individuals, as to show that men of experience who have given thought to the present problems have in all sincerity arrived at conclusions that cover a wide field of divergence. In some respects the failure of the Draft Interim Report to reach Australian practitioners may not be a handicap, for they have had to form their opinions without its aid; its source of origin would almost certainly have influenced some persons to accept its views without giving much thought to the subject themselves. Now Australian doctors will be able to compare their own ideas with those of English observers and for this reason the Interim Report should be read and re-read by every practitioner in the

Commonwealth. Fortunately it is possible to publish the report before the meeting of the Federal Council on March 15. The Federal Council will have before it the views of the Branches on the several schemes of medical service which it considered at its last meeting and which it asked the Branches to discuss, and it will be certain to use the interim report in the way that its authors intended practitioners in Great Britain to use it—as a basis for discussion, comment and criticism. In these circumstances any document sent to the several Branches by the Federal Council after its next meeting will surely be regarded as based on sound and reliable data and therefore worthy of most serious consideration.

In asking readers to study this interim report, the first point to which we would direct attention is the terms of reference stated in the first clause: "To study wartime developments and their effects on the country's medical services both present and future." The words might have been more happily chosen. It would be simple to suppose that any need to plan a complete medical service for the nation was due solely to the advent of the war—that the present system of medical practice was defective because of wartime conditions. No thoughtful person could hold this idea for long. The Medical Planning Commission certainly does not do so; this is clear from the criticism it makes of present medical services. It is important to remember, as a correspondent has recently stated in this journal, that medicine in this country "is a part of medicine of the whole world and of medicine of 2,000 years, moving on from age to age as one magnificently purposeful whole". Medicine, moving on with purpose from age to age, must advance; it must advance as civilization advances. It has its own life, in which it must develop and pass from one triumph to another, but it is not an exotic exhibit to be set on high as it were and treasured as a rare example of art is treasured. It is the servant of man. As man's needs change medicine must try to meet them. During the last few decades the face of society has gradually been changing, and before the war medicine in its relation to society was lagging behind. The war has intensified the change in society and has shown beyond doubt that further changes will take place after the war the extent of which cannot be gauged. Medicine cannot lag behind any longer; it must fulfil its purpose and can do so only by adjusting itself to the altered needs of society. All this is so obvious and has been stated so often, it will be said, that repetition is absurd. Such an observation would not be correct. There are still in the ranks of medicine some who refuse to see what is staring them in the face, even as there are some who will be quite happy to see changes, even extensive changes, in the branch of medicine to which they do not belong, provided no change affects them or those who move in their exclusive professional circles. The objects of medical service are set out in the report as two in number, and with them no medical practitioner can quarrel—to provide a system of medicine which will prevent disease and relieve sickness, and to make available to everyone in the community all necessary medical services. These objects cannot be achieved unless the whole profession is united in willingness and in earnest endeavour to achieve them.

Turning to the report itself, readers will note that frequent reference is made to national health insurance

practice which, of course, does not exist in Australia, and also to the British hospital system which is different in many respects from hospital practice in this country. In spite of these differences the general principles dealt with in the report apply in Australia with just as much force as they do in Great Britain. Section 23 of the report sets out in simple language the steps which should be taken in the public interest to improve the medical service to the community. "Doctors must be competent and have time to devote to those medical services which they undertake to give. They must have facilities for rendering them at the highest level of efficiency." This may be put in another way—that no form of medical service is to be regarded as acceptable if it piles on to the practitioner more work than he can reasonably be expected to do and if it is so planned that facilities are inadequate and deterioration in efficiency is likely to occur. It should be noted that reference is made to the "convenience and comfort" of the public. This is rightly emphasized and must always be one of the chief considerations in any scheme of medical service. The public has to avail itself of the arrangements made for its health and well-being; it will not do this if the arrangements are either inconvenient or uncomfortable. There is something to be said, too, for the convenience and comfort of the doctor. Perhaps these are not quite the right words to use. Convenience is necessary in the working arrangements that are made for him or that he is permitted to make for himself—facilities of diagnosis and of collaboration with consultants and specialists. Comfort should be thought of for the doctor in the sense that he should work under congenial conditions and have sufficient leisure to be able to renew his medical knowledge from time to time and his bodily and mental vigour by suitable relaxation. The report states that verbal tribute is often paid to the important place of the general practitioner in the pattern of health services. Those who have the planning of a medical service for Australia have the opportunity of so placing the general practitioner that his undoubtedly abilities may have full play. Of his willingness to use his abilities there is no doubt. The report devotes a good deal of space to group practice and a model health centre is described. This section should receive special attention. Much can be said for the ideas that are here advanced and elaborated. Many faults can also be found with the so-called model, but the present occasion should not be used for its dissection. Readers would find it useful to set down in black and white the advantages and disadvantages of the "model health centre". In this way they would clarify their own ideas and perhaps find new ones. This suggestion might with advantage be applied to the whole report, and with this remark it must be left in the hands of readers that they may "read, mark, learn and inwardly digest" it.

### Current Comment.

#### IMMERSION FOOT.

THE submarine warfare in the North Atlantic has brought into prominence a pathological condition known as immersion foot. In a most interesting and informative article, Surgeon Commander D. R. Webster, Surgeon Lieutenant F. M. Woolhouse and Surgeon Lieutenant J. L.

Johnston state that immersion foot is a condition produced by long immersion of the feet in extremely cold water, and that it is usually associated with immobility of the limbs and their constriction by boots and clothing.<sup>1</sup> It is similar to the conditions known as trench foot and shelter foot. These authors have recently made observations in 142 of these cases, almost all of them the result of enemy action in the North Atlantic. The patients had been in lifeboats or on rafts for periods varying from thirty hours to twenty-two days. The boats almost always contained water to a depth of several inches in spite of constant bailing. At the outset the authors point out that the only recorded temperatures of the water showed it to be from 34° to 36° F. The freezing point of sea water is approximately 28.5° F., and it is thought that the feet may well have been exposed to surface cooling below the freezing point of blood, which is 31° F. Apparently the condition can occur without exposure to extreme cold, for one of the authors in question has observed immersion foot among survivors (it is not stated how many) who had been in the Gulf Stream, where the temperature of the water was between 60° and 70° F. According to Surgeon Commander C. C. Ungley,<sup>2</sup> who writes about eighty cases seen in Scotland during the last two and a half years, the essential cause of the condition is exposure of the limbs to cold insufficient to freeze the tissues. The condition is not frost bite, for frost bite is due to actual freezing of the tissues. Ungley states that parts of the body immersed in water cannot be frost bitten because the freezing point of the tissues is lower than that of sea water. Immersion, he holds, has no specific action apart from its effect in keeping the parts cold; sometimes the hands, although not immersed, are damaged as much as immersed feet. "An exactly similar condition . . . affected the ungloved hand of an airman who had lain exposed for 22 hours on a snow-covered mountain."

Webster, Woolhouse and Johnston state that when the sufferers in their series were removed from the open boats or rafts, their feet were cold and swollen and waxy white in colour, with scattered cyanotic areas. The patients complained that their feet felt heavy, "woody" and numb, and the feet were anaesthetic to painful, tactile and thermal stimuli. As soon as the feet were removed from the water, the swelling increased rapidly, and the feet became red, hyperemic and hot without sweating. The pulse in the vessels of the feet was full and bounding. In the more severely damaged areas the parts remained oedematous and hot, and assumed a livid, cadaveric appearance. In some of these areas blebs appeared at a later stage, and some of the blebs were filled with straw-coloured fluid and others with extravasated blood. Areas of ecchymosis were commonly present. Many of the feet presented the appearance of incipient massive gangrene. The anaesthesia presented a variety of patterns. Ungley describes the symptoms and signs in the affected limbs as occurring in three stages. The first stage is the pre-hyperemic stage and lasts from a few hours to several days. This is followed by the hyperemic stage which may last for a period of from six to ten weeks. His description of the lesions at this stage is much the same as that given by Webster and his collaborators. Ungley's third stage is the post-hyperemic stage which may last for weeks or months after the hyperæmia has subsided. More important than division into stages is a grouping according to severity. The cases in the series presented by Webster, Woolhouse and Johnston were classified in four groups. In Group I, which comprised 39 cases, erythema only with slight sensory changes was present. In Group II (38 cases), the mild cases, pitting edema, erythema and sensory changes were noted. In Group III (50 cases), the "moderate" cases, pitting edema, erythema, blebs and ecchymotic spots were present. In 15 "severe" cases, Group IV, there were gross pitting edema, blebs, massive extravasations of blood and incipient gangrene. Interest for Australians will centre round the observation that a considerable variation in the individual response to the kind of trauma in question was noted. Webster *et alii* state that Knight, who wrote on

<sup>1</sup> *The Journal of Bone and Joint Surgery*, October, 1942.

<sup>2</sup> *The Lancet*, October 17, 1942.

trench foot in civilians in the *British Medical Journal* in 1940, has attributed this variation in part to a nutritional deficiency. In the Webster series it was observed "that those who suffered the most severe damage were Greeks, Australians, Negroes, and those employed in engine-room or stokehold duties". This suggested to the observers that those accustomed to a warm environment might not have the same defences as those who had been exposed to colder climates.

From the practical point of view the chief interest in the paper of Webster and his co-workers lies in the method of treatment adopted and the good results obtained. All the patients in Groups I, II and III, with one exception, recovered completely after superficial desquamation over the entire foot and a brief period of reeducation necessitated by abnormal gait. The one exception was a patient who died following the development of empyema and staphylococcal septicaemia. The patients in these three groups were in hospital on an average for 30·4 days. Of the 15 patients in Group IV, seven were discharged from hospital after the loss of small areas of superficial tissue which healed rapidly and did not require grafting. The remainder were still in hospital when the article was written. In these cases tissue defects of varying extent have developed, and these are described in detail. Treatment consisted in dry cooling and refrigeration. Webster and his co-workers point out that the tragic results from the too rapid warming of feet injured in this way have often been demonstrated. In the present series three different methods were used. At the same time we are told that apparatus is being constructed which will produce uniform dry cold and the results will be recorded later. The first method consisted in the application of ice bags. The feet were swabbed carefully with alcohol. Pledgets of gauze were placed between the toes and the whole foot was covered with a sterile towel. Five carefully dried ice bags were placed around each foot over the towel and the whole was enclosed in an oiled silk bag. This was then wrapped in layers of cellulocotton and enclosed in rubber pillow cases, loosely tied about the upper part of the calf of the leg. The feet were then raised on several pillows. The ice bags as a rule were changed every four hours. The second method of dry cooling consisted in exposure and elevation in front of electric fans. While a continuous blast of air was played on the feet, the feet were sprayed through the fan blades with cold water from a nebulizer. In the third method of dry cooling the feet were elevated and completely exposed to room temperature in a cool ward. It is perhaps interesting to note that in one of the Group IV cases ice bags were applied for four weeks, the tissues of the feet assumed a healthy pink colour and the ice bags were removed. When the feet were exposed to room temperature a large quantity of blood was extravasated into the subcutaneous tissues within eight hours. The feet became greenish-grey in colour. A sharp line of demarcation occurred and extensive loss of tissue is expected to take place. In his discussion on treatment Ungley lays great stress on the need to avoid even trivial injury of the damaged feet. He leaves the feet dry and exposed to the air and raised on pillows. Of "dry cooling" he merely states that beneficial results have been reported from Canada with the use of fans and ice bags.

Webster and his collaborators state that the rationale of this treatment rests on the presumption that the tissue damage caused by the original trauma results in an intense vasodilatation together with actual damage to the vessel walls and damage to peripheral nerves or end-organs. "A vicious circle is thus established, with a resulting oedema and transudation of serum and blood, all of which further contribute to the already present oxygen debt in the involved parts. This latter, in turn, leads to an increase in oedema and transudation of whole blood." It was thought that if the metabolic demands of the part could be reduced until the oedema subsided, the extravasated blood was reabsorbed and the vasomotor tone was reestablished, the tissue damage would be lessened. That this supposition was justified is clear from the results

obtained. It should perhaps be noted that dehydration was not a complicating factor in the Webster series. The men were survivors of sinkings by enemy action in the waters of the North Atlantic; they had a plentiful supply of fresh water and were at no time exposed to tropical heat.

In our account of these Canadian and Scottish observations attention has been directed chiefly to their practical aspects. In regard to pathogenesis much work remains to be done. Ungley states that work is still in progress and that some of his statements may need correction or amplification. Webster, Woolhouse and Johnston point out that there are many unsolved problems in the study and treatment of the condition, problems to do with nerve dysfunction, vascular damage, the formation of H-substance and remote toxic effects. Ungley thinks that the term "immersion foot" should not be used, but that the condition should be described as "peripheral vasoneuropathy after chilling". It is unlikely that this term will be adopted until the gaps in knowledge have been filled.

#### SEA WATER FOR THE TREATMENT OF DEHYDRATION.

As far as is generally known neither side in the present conflict has solved the problem of using sea water to prevent dehydration in persons cast adrift from ships. The value of a device for making sea water potable in such circumstances is at once apparent either in peace or war, since the chance of survival in an open boat is dependent on the availability of water and to a much less extent on the availability of food. Unfortunately distillation is not entirely suitable for use in small boats owing to the bulk of the apparatus and the difficulty of supplying a source of heat. The chemical approach to this problem is the one which offers the greatest promise, either by the precipitation or by the adsorption of the salts from sea water. However, the successful development of this method has not been achieved. The third possible approach to this subject, that is, from the physiological aspect, has been discussed recently by R. F. Bradish, M. W. Evdhart, W. M. McCord and W. J. Witt,<sup>1</sup> and although their findings were negative they are nevertheless important. As these authors state, the absorption of sea water by the body would necessitate the concentration of a solution which is already hypertonic to the blood, and is therefore unlikely. Sea water taken orally acts as a cathartic, emetic or diuretic, each of which rules out this route of administration, with the exception that in hot climates a small amount of sea water may be added to the fresh water to replace the amount of salts lost by sweating. If sea water is taken by mouth and is absorbed by dehydrated persons in whom fluid is not available for excretion with the salts in the urine, then these salts will be retained in the tissues; this will increase the osmotic pressure, withdraw fluid from the blood and give rise to the anomalous condition of oedematous dehydration.

Absorption of sea water after rectal injection is unlikely on theoretical grounds, and Bradish and his fellow workers found that in practice it did not occur. These authors were careful to reproduce the conditions of dehydration and exposure in their experiments, but in none of their subjects did a diminution of thirst or an amelioration of symptoms occur. Repeated analyses of the fluid at intervals after the instillation into the rectum showed that the sodium chloride content decreased, that is, the sodium chloride was being absorbed at a greater rate than the water, an undesirable state of affairs in dehydrated patients. Bradish and his co-workers suggest the use of salt free rations in conjunction with an amount of sea water containing salt equal to that amount omitted from the rations. This suggestion is being investigated and should partly solve the problem of the maintenance of life in an open boat, but it would seem that the use of precipitating or adsorbing agents is more likely to supply the final solution.

<sup>1</sup> *The Journal of the American Medical Association*, October 31, 1942.

## Abstracts from Medical Literature.

### PAEDIATRICS.

#### Treatment of Rheumatism.

JOHN ZAHORSKY AND T. S. ZAHORSKY (*Archives of Pediatrics*, September, 1942) give some additional explanatory comments on a paper previously published by them in which they recorded results obtained in a few cases of rheumatism by the administration of a sulphonamide followed by an anti-rheumatism drug. The latter was a mixture of acetylsalicylic acid and sodium benzoate. Many years ago pharmacologists insisted that in order to obtain the full physiological action of sodium salicylate it was necessary to give very large doses—a quantity which approached very closely the toxic dose of the drug. While children tolerate this chemotherapy very well, the authors found many practical objections to giving 100 grains or more of this drug to a child. They began to use acetylsalicylic acid, but as a great part of this chemical is absorbed in its combined state, the antipyretic and depressing effects were undesirable, even dangerous. Various combinations were tried, but finally it was decided that the benzoate of soda enhanced the antirheumatic effect of the acetylsalicylic acid very much, so that only moderate doses of the latter drug were needed. This mixture—equal parts of acetylsalicylic acid and benzoate of soda—became the authors' favourite antirheumatic remedy and they used it for many years to allay fever and joint pains in the acute rheumatic fever of children. The daily dose of the mixture varied from one-half to one grain per pound, according to the severity of the symptoms. The authors do not claim any particular or decided advantage of this combination of drugs over other forms of the salicylic acid treatment. They wish to emphasize that it was this combination of drugs which was given to their patients after two or three days' treatment with sulphonamides. They therefore did not decide whether the salicylate of soda in moderate doses might act just as well. Since some recent pharmacological experiments mention a benzoate compound as inactivating the "sulpha drugs" there may be some objection to the use of benzoate of soda. However, purely clinical trial by the authors gave gratifying results, and without attempting an explanation they will try it in other cases. Possibly the sulphonamides in this disease do not act as bactericidal chemicals, but merely prepare the ground for an effective action of the salicylates or benzoates. As the pathogenesis of rheumatic fever has not been satisfactorily clarified, it is futile to speculate on the mode of action. If the conclusions of Coburn are accepted that a haemolytic streptococcus is the primary cause of rheumatism and the peculiar manifestations are the sequel of sensitization to the toxin or streptococcal nucleo-protein, it does seem logical to make an effort to destroy the streptococcus at the initial stage of the disease. The authors repeat the directions: Administer sulphathiazole (daily dose three-quarters to one grain

per pound) from two to three days. Then discontinue this drug and in a few hours administer, preferably in capsules, equal parts of acetylsalicylic acid and benzoate of soda (daily dose three-quarters to one grain per pound). The authors suggest that other practitioners try this treatment.

#### Nephritis and Varicella.

DOROTHY GILL (*Archives of Pediatrics*, September, 1942) reviews thirty-six cases of nephritis following chicken pox collected from the literature in regard to incidence, age and sex, precipitating factors, clinical course and duration of the disease. The author also reports a case of haemorrhagic glomerulonephritis following varicella. Of the contagious diseases of childhood varicella is considered one of the less serious. Complications may arise, but are relatively infrequent. Bullowa and Wishik reported fewer complications in chicken pox than in scarlet fever, measles, diphtheria or pertussis. Among their 2,534 hospital patients suffering from varicella, only 5·2% developed any complication, and the mortality rate was only 0·4%. *Otitis media*, abscess, pneumonia, lymphadenitis, septicaemia and cellulitis occurred most often. Nephritis was first recognized as a complication of chicken pox by Henoch in 1884. Sporadic confirmatory reports appeared for some years thereafter, the cases ranging in severity from transient albuminuria to uremia with death. Few conclusions were drawn as to the incidence, the precipitating factor, the course of the disease or the prognosis. In the series there was a predominance of females and the ages ranged from six months to eleven years. In regard to the precipitating factors in most of the cases the varicella itself presented no unusual features or associated infections. In one there was an accompanying streptococcus infection. In another, preceded by measles, streptococci were cultured from the blood and from fluid draining from cellulitis of the neck. A few authors have made specific mention of a haemorrhagic or abnormal type of rash, but most cases seem to have been of the usual variety. The onset of the nephritis was usually marked by the appearance of fever, oliguria, increasing oedema of the face and extremities, and occasionally gross haematuria. Convulsions are described only twice and elevations of blood pressure twice also. The urine uniformly contained albumin and a variable number of red cells and casts. The follow-up of the thirty-six patients was entirely inadequate. Of the twenty-nine who recovered, twenty-five were discharged from hospital as cured as soon as the urine cleared and the findings on physical examination became normal, this requiring from four days to "many weeks". Of the remaining four, one had albumin and casts in the urine for a year and was still being observed at the time of the report. Another had a recurrence of the nephritis three months later when he developed pneumonia; three weeks after recovery albumin was still present in the urine.

#### The Feeding of Healthy Infants and Children.

PHILIP C. JEANS (*The Journal of the American Medical Association*, November 21, 1942) has contributed a special article on the feeding of healthy

infants and children under the auspices of the Council on Foods and Nutrition. He points out that feeding at the breast of the mother remains an ideal procedure. Vitamin D is needed early by all babies, whether breast or artificially fed. Vitamin C is needed early by artificially fed babies and is a harmless safeguard for the breast-fed baby. No need for vitamin A from special sources exists. If current custom is in error it errs in the direction of giving too much vitamin D and too little vitamin C and in not giving either of these materials early enough. Additional supplementary foods should be given not later than four months of age to both breast and artificially fed babies. One important function of these supplements is to supply iron and vitamins of the B group. Another function is to accustom the baby early to variety in flavour and texture for the promotion of good feeding habits. Anorexia and poor feeding habits, which occur so frequently in older children, often have their origin in feeding mismanagement in infancy. In a general way reasonably satisfactory progress has been made in regard to the nutrition of babies, but not to the same extent as regards children who are past infancy. The nutrition of the child has been improved during the past generation, but not to the extent desirable or possible with present knowledge. Though observers do not agree too well as to the particular nutritional or dietary factors responsible for dental caries, nearly all are of the opinion that one or more dietary components may be responsible, either by lack of those which are essential or by the presence of some considered harmful. On such a basis dental caries is the most widespread nutritional scourge. At least three nutritional essentials deserve special emphasis in childhood, namely, vitamin D, protein and calcium. Vitamin D is required throughout the growth period, a fact which is extensively overlooked. Milk as the only constant good food source of calcium is not taken in sufficient quantity by a large number of children. Protein deficiency is much more common than is generally realized. A diet adequate in protein cannot be arranged fortuitously without the inclusion of milk. Though thiamin is obtained by a large proportion of children in quantities scarcely meeting their needs, the remedy lies in better food selection, not in thiamin medication. Enrichment of flour and bread and decreased consumption of sugar should contribute materially to the desired end. Vitamin A from special sources is not needed by the normal child. A diet fortuitously deficient in vitamin A is deficient also in other respects. A remedy is a better diet, not medication.

#### Post-Vaccinal Encephalitis.

C. L. DAVIDSON AND JEAN TERRY THOMAS (*Archives of Disease in Childhood*, September, 1942) report recovery from post-vaccinal encephalitis following treatment with the intravenous administration of "Pentothal Sodium" and convalescent serum. Encephalitis has now been recognized for many years as a rare but serious complication of vaccination, and some hundreds of cases have been reported. Its incidence is mainly in older children and young adults undergoing primary vaccination and it is extremely rare in

the first year of life. Thus in Holland in 1929 there were eighty-three cases resulting from about one and a quarter million vaccinations, none of the infections affecting infants under the age of twelve months. In England only eight cases in infants were reported to the Ministry of Health in the eight years from 1932 to 1939, and of these five were fatal. The rarity and seriousness of the condition are thus evident. The authors' case, in which an infant aged four months recovered, is recorded for two reasons—firstly because of its rarity, and secondly to draw attention to the efficacy of "Pentothal Sodium" and convalescent serum in treatment. "Pentothal Sodium" is a valuable addition to the armamentarium of the paediatrician in the control of convulsions in infants and small children and has, in the experience of the authors, brought an end to the convulsions of three infants in the treatment of whom all other measures had proved ineffective. In the present case the most pressing indication for treatment was provided by the persistent restlessness, convulsions and respiratory distress which in themselves seemed to constitute a threat to life. Previous therapy with increasing doses of bromide and chloral, lumbar puncture, repeated chloroform inhalations and morphine had been without effect in the relief of their symptoms. An intravenous glucose saline infusion was begun and 0.025 grammes of "Pentothal Sodium" was given with the first two to three ounces of fluid. The effect was immediate and dramatic. Within a minute or two general muscular relaxation occurred and respiration, though still rapid, became quiet and peaceful; it was as though natural sleep had suddenly supervened on a severe delirium. During the next two hours five ounces of convalescent serum were given followed by glucose and saline solution to a total of 15 ounces. No further convulsions occurred, but the respiration rate remained high. The child's condition was greatly improved and it was able to take feeds by mouth. Two days later the temperature fell to normal and the general improvement was maintained. The child was discharged from hospital six days after admission, apparently well. At the age of ten months the child appeared normal.

#### ORTHOPÄDIC SURGERY.

##### **Stainless Steel Plates and Screws in Bone Surgery.**

J. A. KEY (*Archives of Surgery*, October, 1941) reviews the literature on internal fixation of bone and publishes the results of experiments on different materials used in plating fractures and other bone surgery. Amongst the factors considered in the experiments are aseptic technique, adequate mechanical fixation, reaction of tissues to the foreign substance, results of corrosion, the electric currents set up by contact of different metals. Various alloys have been tested and include chromium, nickel, vanadium, molybdenum combined with steel. Copper, magnesium, aluminium, brass and bronze are very toxic; silver, nickel and chromium are moderately toxic; gold and stainless steel are of minimal toxicity. Stainless steel and vitallium

screws and nails were left in the femurs of dogs for thirteen months. Vitallium is an alloy which cannot be rolled or drawn, but must be cast. Stainless steel 18% to 20%, chromium 8% to 10%, nickel and small amounts of carbon, manganese, silicon, phosphorus and sulphur is the alloy of choice and equally good is one consisting of 16% to 20% chromium, 14% nickel and 2% to 4% molybdenum.

##### **Recurrent Dislocation of the Shoulder.**

F. C. BOST AND V. T. INMAN (*The Journal of Bone and Joint Surgery*, July, 1942) discuss the pathological changes in recurrent dislocation of the shoulder. They base their remarks on ten cases in which they performed Bankart's operation. They state that Bankart regarded a detachment of the *labrum glenoidale* from the anterior aspect of the glenoid rim as the "essential" and sole lesion in recurrent dislocation of the shoulder. Bankart, they state, believed that the essential lesion had been overlooked, because the demonstration of the tear of the *labrum glenoidale* requires a special exposure of the shoulder joint. Bankart devised an operation for the repair of the tear and held that when this was done recurrence of the dislocation was prevented. The authors discuss shortly the findings of other observers, but give Bankart credit for having made it possible to link together the complete picture of the pathological changes in recurrent shoulder dislocation. The authors describe in some detail the pathological findings in their six cases. From these they go somewhat further than Bankart and describe what they call a triad of pathological findings which they regard as essential to the aetiology of the condition. This triad consists of: (a) detachment of the *labrum glenoidale* and the anterior capsule of the shoulder joint, (b) a defect in the postero-lateral portion of the head of the humerus, (c) erosion or fracture of the glenoid rim. They therefore describe a recurrent dislocating shoulder as "one which has sustained an avulsion of the *labrum glenoidale* and capsular anchorage, with stubbing of the glenoid rim and some destruction of the postero-superior aspects of the articulating surface of the humeral head". In such cases the head is supported only by the shallow concavity of the glenoid fossa, because the detached labrum and capsule offer no resistance to the dislocating force. If the shoulder is dislocated habitually, secondary changes appear as a result of the development of traumatic arthritis. These changes are proliferation of bone about the scapular neck, eburnation of the glenoid rim, production of loose bodies, synovial thickening and cartilaginous disintegration.

A. L. EYRE-BROOK (*The British Journal of Surgery*, July, 1942) describes the morbid anatomy in a case of recurrent dislocation of the shoulder. The patient, a woman, aged thirty-six years, collapsed and died during the performance of an operation for the cure of a dislocation which had recurred at intervals during a period of nine years. During the last three years before operation was undertaken, the shoulder had been dislocated twenty-five times. The pathological changes found included detachment of

the capsule and glenoid labrum from the rim of the glenoid and a large posterior notch in the head of the humerus with reduction in size of the anterior lip of the glenoid cavity. No loose bodies were found in the joint, nor were there any other abnormalities in the head of the humerus. It was concluded that the posterior notch in the head of the humerus had developed from erosion and absorption, the result of intermittent pressure, and that similar changes had occurred in the anterior lip of the glenoid cavity. The author points out that these changes would have been occurring over a period of nine years. The perfect adaptation of the surface of the notch to that of the anterior lip of the glenoid, both of which surfaces consisted of smooth, bare bone, was thought to be irrefutable evidence in support of this view. The development of the notch on the posterior surface of the humeral head and the absorption of the anterior lip of the glenoid would account for the increasing frequency and ease of dislocation which is an invariable feature in recurrent dislocation of the shoulder.

##### **Sulphonamides and Compound Fractures.**

C. L. MITCHELL (*Surgery*, September, 1942) discusses the local use of sulphonamide drugs in the treatment of compound fractures. The results in controlling infection in such cases by the oral use of these drugs have been disappointing. But the local implantation of the drug may produce a very high local concentration, and thus be more effective. It is not easy to evaluate the results of this treatment scientifically because of the impossibility of providing comparable controls. At the Minnesota General Hospital, however, the general infection rate in compound fractures, which had been from 25% to 28%, was reduced after the introduction of local sulphonamide treatment to 4.9%. At the Henry Ford Hospital the infection rate was reduced from 20% to 9.7%. In war surgery the results of compound fractures have been improved by abandoning the practice of closing these wounds and by the use of the closed plaster method. It is thought that if sulphonamide could be implanted into the wounds as a first-aid measure at the earliest possible moment, the results might be still further improved. Caldwell has shown that in laboratory animals, sulphathiazole powder introduced immediately into wounds contaminated with *Bacillus welchii* prevented gas bacillus infection in 100% of cases. When the powder was introduced one hour after the introduction of the organisms, 77% of the animals died of gas bacillus infection. It has been suggested that these drugs might have a delaying effect on the healing of wounds. Key and others have shown experimentally that although there is delay in the first few days, due probably to excessive serous exudate, the wounds heal completely in the same time as the control wounds. This same observation was also found to apply to the formation of callus and to bone healing. The author again stresses the point that the use of these drugs locally must in no circumstances lead to an abandonment of established surgical principles or to lack of care in the *débridement* of the wounds concerned.

## British Medical Association News.

### MEDICO-POLITICAL.

A CONVENTION of representatives of medical organizations in the State of New South Wales with the Council of the New South Wales Branch of the British Medical Association was held at the Robert H. Todd Assembly Hall, British Medical Association House, 135, Macquarie Street, Sydney, on February 5 and 6, 1943, Dr. W. F. SIMMONS, the President of the Branch, in the chair.

The convention had been called by the Branch Council for the purpose of discussing all types of schemes for a general medical service for Australia including the present type of service, and of recommending the type of service that was considered to be in the best interests of the community. Those present, and the bodies which they represented, were as follows: Dr. W. F. Simmons (President of the New South Wales Branch of the British Medical Association); Dr. A. J. Collins (Honorary Secretary of the New South Wales Branch of the British Medical Association); Dr. George Bell (Honorary Treasurer of the New South Wales Branch of the British Medical Association); Sir Charles Blackburn, Dr. G. M. Barron, Dr. K. S. M. Brown, Dr. A. M. Davidson, Dr. L. A. Dey, Dr. B. T. Edye, Dr. T. M. Greenaway, Dr. H. R. R. Grieve, Dr. P. L. Hipsley, Professor W. K. Inglis, Lieutenant-Colonel A. C. Thomas, Dr. E. A. Tivey, Dr. W. Vickers, Professor H. K. Ward (members of the Council of the New South Wales Branch of the British Medical Association); Dr. J. G. Hunter (Medical Secretary of the New South Wales Branch of the British Medical Association); Dr. H. Hunter (Assistant Medical Secretary of the New South Wales Branch); Dr. R. A. Robertson (Border Medical Association); Dr. A. E. Panting (Broken Hill Medical Association); Dr. H. A. McCredie (Canterbury-Bankstown Medical Association); Dr. R. G. Woods (Central Southern Medical Association); Dr. O. J. Ellis (Central Northern Medical Association); Dr. G. N. M. Aitkens (Central Western Medical Association); Dr. J. P. Hardie (Eastern Suburbs Medical Association); Dr. N. E. McLaren (Eastern District Medical Association); Dr. E. A. C. Marshman (Far South Coast and Tablelands Medical Association); Dr. G. F. Elliott (Illawarra Suburbs Medical Association); Dr. G. L. Howe (Kuring-gai District Medical Association); Dr. R. J. Jackson (Northern District Medical Association); Dr. J. R. Ryan (North-Eastern Medical Association); Dr. Glennie Holmes (Southern District Medical Association); Dr. C. H. Jaede (South Sydney Medical Association); Dr. A. L. Caselberg (South-Eastern Medical Association); Dr. M. H. Elliot-Smith (Warringah District Medical Association); Dr. R. D. Mulvey, M.C. (Western Medical Association); Dr. H. M. Rennie (Western Suburbs Medical Association); Dr. A. D. Morgan (Section of Anesthesia); Dr. W. S. Dawson (Section of Neurology, Psychiatry and Neuro-Surgery); Dr. W. L. Calov (Section of Medicine); Dr. J. N. Chesterman (Section of Obstetrics and Gynaecology); Dr. S. H. Scougall (Orthopaedic Group); Dr. D. G. Carruthers (Oto-Rhino-Laryngological Society of New South Wales); Dr. R. A. R. Green (Section of Paediatrics); Dr. O. Latham (Section of Pathology and Bacteriology); Dr. J. W. S. Laidley (Section of Urology); Dr. D. G. Maitland (Section of Radiology); Dr. J. Cooper Booth (Section of preventive medicine); Dr. Darcy Williams (Ophthalmological Society of New South Wales); Dr. H. G. R. Poate (Royal Australasian College of Surgeons); Dr. H. H. Willis (Public Medical Officers' Association); Dr. Addie Walker (Medical Women's Society of New South Wales); Mr. J. W. Hornbrook (University of Sydney Medical Society); Surgeon Lieutenant-Commander E. Susman (Royal Australian Navy); Lieutenant-Colonel S. G. Nelson (Australian Commonwealth Military Forces); Squadron Leader D. C. Howle (Royal Australian Air Force); Dr. J. M. Banks (resident medical staffs); Dr. H. H. Schlink (honorary medical staffs—teaching hospitals); Dr. J. E. F. Deakin (honorary medical staffs—non-teaching hospitals); Dr. T. W. Lipscomb (New South Wales Post-Graduate Committee in Medicine). The Editor of THE MEDICAL JOURNAL OF AUSTRALIA was also present.

### Apologies for Absence.

An apology was read from Sir Henry Newland, President of the Federal Council of the British Medical Association in Australia. Dr. G. C. Willcocks also wrote that he was unable to be present on account of Royal Australian Air Force duties.

### Message of Goodwill.

The Medical Secretary read a message of goodwill from the Royal Australasian College of Physicians. In the course of the letter it was stated that the Royal Australasian College of Physicians would confer with the Royal Australasian College of Surgeons and with the Federal Council of the British Medical Association in Australia before it stated its opinion. No pronouncement would be made by College which was at variance with any agreement reached by these three bodies. The Royal Australasian College of Physicians was engaged in considering a national medical service as it affected its own Fellows and Members and would shortly formulate its policy based upon reports from special committees set up in each State. The College held that no scheme should be instituted while the war lasted.

### Introductory Remarks and Official Opening.

Dr. W. F. Simmons welcomed the representatives to the convention and also extended a cordial welcome to Dr. J. A. Cahill, the President of the Victorian Branch of the British Medical Association, and Dr. David Roseby, the senior Vice-President of the Victorian Branch. Dr. Simmons said that the gathering was unique in the history of the British Medical Association in Australia. No convention had previously been called, and the Council had welcomed the suggestion made by the annual meeting of delegates of local associations that the convention should be called. Dr. Simmons then called upon Sir Charles Blackburn, as senior member of the Branch Council, to open the proceedings officially.

Sir Charles Blackburn said that he wished in the first place to express his appreciation of the signal honour of having been invited to make the inaugural remarks. He had not lightly accepted the invitation, because he felt that it was a great responsibility to attempt to set a key note for the important discussions that were about to take place. However, he thought that possibly there were a few points that he had set down which might help to steady in some way the nature of the considerations and discussions that were to follow. He intended to be brief, because in that respect he wished to set a good example to the rest of the members.

Sir Charles Blackburn went on to say that the potential value of the conventions called in the various States was tremendous; but their actual helpfulness to the Federal Council that had called them would depend to a great extent upon whether, at least with regard to the main issues, there was considerable uniformity in the recommendations made. It was therefore of the utmost importance that in the convention in each State the delegates should constantly keep in mind that they were carrying a great responsibility, and when they were taking part in a discussion they should endeavour to make their contribution logical, dispassionate and helpful, and in particular uncoloured by personal bias and self-interest.

It was obvious from the large number of notices of motion on the business paper that the meeting had been preceded by full discussion in the various professional groups sending delegates to the convention, and that the meeting should be able to transmit to the Federal Council the view of a representative cross-section of medical practitioners in New South Wales. Sir Charles Blackburn, however, reminded those present that their usefulness to the Federal Council would be in proportion to the number of decisions at which they arrived and not to the time they spent in discussion. He therefore asked them to concentrate on basic principles, and not to spend too much of their limited time in debating matters that must really be contingent upon the nature of any particular scheme of practice adopted. He felt sure that none of those present imagined that a complete Commonwealth-wide scheme for conducting medical practice in all its complicated details could be drawn up in a single week-end discussion; but if agreement could be reached on broad outlines, it would, of course, be quite competent for delegates to decide to meet again later to discuss details. He especially stressed the fact that the occasion had afforded them an exceptional opportunity to demonstrate unmistakably that their guiding principle in formulating a health policy was that it should be the one that in their carefully considered opinion was best fitted to establish and maintain the health of the nation at its highest possible level. The context of such a scheme should clearly indicate how great was the importance attached to ensuring that the unborn child should be as perfectly prepared to enter upon its extrauterine existence as science could devise, and that thereafter its mental and physical development during its most important formative period should be carefully super-

vised in a suitable environment; that when it reached adult years and took its place in the community, every possible care should be taken to protect it as far as was humanly possible from being affected by the various prevalent infections; that the adult should be cared for in regard to industrial diseases; and that in the event of his contracting some complaint which would withdraw him from his occupation, he and his family should be the care of the community. It was equally important, when the curative aspect of medicine was under discussion, to explain that the convention had given particular attention to the psychic basis that in some degree underlay, distorted or overshadowed almost every departure from normal health. Unless it could be made perfectly clear to the layman that any scheme that merely provided a routine service for physical ills and overlooked personality was doomed to failure, it would be impossible to make him appreciate either the value of the relationship between the patient and his family doctor, or the need for making provision that the doctor would be able to give adequate time to each patient he saw.

Sir Charles Blackburn then said that, at a time when the valour and fortitude of the Russians had captured everyone's admiration, he would digress and mention some relevant observations that he had made when visiting some of the excellent Polyclinics in Moscow in 1937. He had found that the Russian medical service, fully cognizant of the importance of both the aspects of medical practice to which he had just referred, had adroitly provided for them. Thus, by instituting special clinics for particular groups of workers and their families, one for heavy industries, another for textile industries and so on, they secured a continuity of personal contact between patient and doctor, while proper investigation of each case was ensured by strict limitation of the number of patients allowed to be seen in a given time. The number varied slightly according to the particular department attended, but Sir Charles Blackburn recalled that the number in the medical department was three in an hour.

The speaker went on to say that if he seemed to have laboured the need for indicating with the utmost clarity how any recommendations made would promote the public welfare, it was because of his unhappy recollection of what happened at the time when national health insurance was under discussion. Those present would remember that on that occasion, though their representatives endeavoured to make it clear that their unwillingness to agree to the terms offered was based upon their knowledge that it would not be possible to give a proper service if they were accepted, this aspect of the discussion was steadily ignored in the official reports of the proceedings, with the result that the public was led to believe that the negotiations had broken down because of the extortionate demands of the medical profession. Sir Charles Blackburn was aware that there was a certain amount of resentment that the discussions to take place would centre to a large extent about a scheme for a medical service submitted by the National Health and Medical Research Council, and that there was a strong feeling that the Federal Government had slighted the medical profession by not coming directly to it for its advice upon matters about which it was obviously most competent to speak. It certainly appeared that, even if it was unmindful of the fact that the existing type of medical practice had been gradually evolved from the days when governments showed little or no concern with the health of the people, and when doctors voluntarily shouldered the responsibility, the Government might at least have felt that it could trust a profession that had shown such a unanimous and wholehearted determination to stand behind it in its war effort. That, however, was of purely minor importance in view of the great issues involved, and the speaker was sure that those present would all contribute to the discussions in as helpful a spirit as they would have done if they were meeting in response to a cordial invitation from the Government. It was, of course, inevitable that there would be a difference of opinion on almost every matter discussed; but if speakers would keep in mind that there was always another point of view besides their own, it should be possible to arrive at some compromise between conflicting opinions. That applied particularly to the most vital subject of debate—the future of medical practice. Sir Charles Blackburn expressed the hope that everyone present was fully impressed with the supreme importance of throwing his weight behind whatever scheme was adopted by the majority. If the whole medical profession was ranged solidly behind a particular scheme, it would be in its power to secure that the scheme was as perfect as it could be within its particular limitations. If, on the other hand,

those present allowed themselves to be split into a number of groups advocating different schemes, they would find themselves saddled with one improvised for them by people with no experience of the problems involved—a scheme that would satisfy nobody. Sir Charles Blackburn was so impressed with the need for unanimity that he intended to conclude his remarks by airing his personal views upon the ethical relationship that should exist between an individual and a society of which he was a member. He firmly believed that acceptance of membership of any society should imply voluntary surrender of a considerable measure of independence in regard to matters of group concern. That being so, all should strictly adhere to the principle that while it was the clear duty of any member of a group who had considered views on matters of common interest to put them forward as convincingly as possible, it was equally his duty, if he failed to convince his hearers, to accept the verdict gracefully and forthwith to support loyally the policy adopted by the majority.

#### The Object of a Medical Service.

Speaking on behalf of the Council, Dr. A. J. Collins moved the adoption of the following broad definition of the objects of a medical service:

(a) To provide a system of medical service directed towards the achievement of positive health and the prevention of disease and the relief of sickness.

(b) To render available to every individual all necessary medical service, both general and specialist and both domiciliary and institutional.

The motion was seconded by Dr. A. M. Davidson and carried.

#### The Free Choice of Doctor and Patient.

Dr. A. J. Collins, on behalf of the Council, moved:

That the free choice of doctor and patient is an essential of any service.

Dr. Collins pointed out that since the war started he had been struck by the fact that great numbers of soldiers in uniform who were able to obtain free treatment by military doctors would still exercise their free choice by seeking private treatment from private practitioners whenever they were on leave. It had been said that when practices were sold the patients did not have a free choice of doctor. Dr. Collins pointed out that if the doctor who bought the practice was not acceptable to patients, he would very soon be changed. The principle of the free choice of doctor meant that the public had the right not merely to choose their first doctor, but also their second and third doctor.

Some discussion took place around the use of the word "and" in the motion. Dr. Collins explained that many members of the Council thought that the free choice of patient by the doctor was also important. An amendment was proposed, altering the word "and" to "by the". After discussion this was put to the meeting and lost. The question was then raised as to whether it would be more appropriate to use the word "desirable" instead of "essential". On the one hand it was pointed out that to maintain that free choice was essential would be to commit the profession to oppose any type of controlled service. On the other hand it was held that if the profession believed that a person had the right to choose his doctor, and the doctor had the right to choose his patient, it should have the courage to say so. Eventually it was resolved:

That the principle of free choice of doctor and patient is an essential feature of any service.

#### The Relationship between Patient and Doctor.

It was resolved unanimously on the voices that the personal relationship existing between patient and doctor should be preserved.

#### The Individual and His Own Health.

On behalf of the Council, Dr. A. J. Collins moved and Dr. R. G. Woods seconded a motion to the effect that whilst the health of the community was a national matter, there was a duty on every individual to accept a direct responsibility for his own health and that of his dependants. The motion went on to state that this individual responsibility should be one of the basic principles in any medical service. Some discussion took place as to whether financial responsibility was intended. Dr. Ryan pointed out that a considerable number of persons in the community were not in a position to accept any financial responsibility whatever. In reply to this suggestion, Dr. K. S. M. Brown

stated that the idea behind the motion was that it was the duty of every individual in the State to be concerned with his own health. Dr. H. R. R. Grieve held that the motion had to do with the philosophical basis of medical practice, and Dr. H. H. Willis thought that it was purely an expression of political doctrine. Dr. A. M. Davidson held that the idea of the preservation of health should be in the mind of the individual from the start; unless it was in his mind, the doctor could not help him. It was only another way of saying: "the Lord helps those who help themselves". Eventually an amendment was adopted and carried as the substantive motion in the following terms:

That whilst the health of the community is a national matter, there is a duty on every individual to accept a moral responsibility for his own health and that of his dependants. This individual responsibility must be a basic element in any medical service.

#### Discussion on a Salaried Service.

Dr. A. J. Collins, on behalf of the Council, moved:

That a whole-time salaried basis for a nationwide medical service is not in the interests of the community.

Dr. R. A. R. Green seconded the motion. Dr. Collins said that the Council considered that the introduction of a salaried medical service would be entirely revolutionary, and he was opposed to it on several grounds. In the first place, Australia was geographically too large for the consistent administration of a salaried service. In the second place a salaried service would lead to the formation of a large civil service which would have to exercise control. He said that a large bureaucracy would be very expensive and unnecessarily officious. The whole-time man in a salaried position who was appointed to do a job would do that job as well as he would do it in any other way. The Council felt that such a statement would not apply to medical practitioners who were engaged in general practice. While many in general practice would work well under any system, some would inevitably slide into a mental apathy which would lead to a lowering of medical standards. Owing to geographical conditions Australia had developed a very virile practice. Under a salaried service the matter would be worked in water-tight compartments and research would be given up. Efforts were being made to turn out from the medical school a self-reliant type of practitioner, but these efforts would be frustrated if a salaried system were introduced. The man would merely do what he was paid to do and rely on others far more than he should. Dr. Collins insisted that in the Government service there was a lag which did not exist in private practice—for example, in Great Britain sulphapyridine was used in general practice for twelve months before it appeared on the panel list as a drug which could be prescribed by panel practitioners.

Dr. H. H. Willis said that he had been sent to the meeting to put before the convention the inevitability of a salaried service rather than its desirability. In the opinion of his association the present system of medical practice as it stood without amendment was bad, and was doomed. Rightly or wrongly, he said, the public regarded the medical profession as a monopoly controlling something which the public wanted. He considered that the great argument in favour of a salaried service was efficiency in administration. After drawing attention to the costliness of a medical service run under the capitation system, Dr. Willis said that if the medical profession ever served under such a system the time would come when it would ask for a salaried service because of the advantages it would give in regard to superannuation, sick leave and breakdown pensions. It was said that the introduction of a salaried service would be revolutionary. Dr. Willis thought that it should be evolutionary. If it were brought in gradually, the profession would have plenty of opportunity to understand it, step by step. That it would be unwieldy was a good objection. Dr. Willis would not agree to any administration from Canberra. Administration should be decentralized, and the bureaucracy to control it should be a trained one. It should have the same tenure in office as high court judges. In this way alone could the scheme be protected from political control. In regard to lag such as Dr. Collins had described concerning the use of sulphapyridine—Dr. Willis said that the Government service prided itself on such a lag. The idea was that a government authority was not there to experiment on the public. Any treatment given in public institutions was sound treatment, there was nothing experimental about it. Experiments

were left to universities and other bodies intended for the carrying out of experiments.

Dr. J. P. Hardie referred to the vote taken at the annual representative meeting of the British Medical Association in September, 1942, when a motion in favour of a whole-time salaried service was defeated by 177 votes to 20. Dr. Hardie thought that the convention should be influenced by the opinion of those in Great Britain who had worked for a generation under a form of health insurance. Dr. Hardie's association feared that the administrative chief of a salaried service would be on an absolutely higher plane than the consulting specialist. This was evidence of a very dangerous and unhealthy tendency and members of the profession did not wish to place themselves in the hands of those who thought along such lines. There was also a danger that the profession would be saddled with officials who had a flair for collecting statistics and would require records to be kept of all conceivable things. An eight-hour day was attractive to many men, but in the opinion of Dr. Hardie's association this was impossible, for there would have to be a continual service when patients suffering from acute and serious illnesses were being treated.

Dr. H. M. Rennie said that he had been instructed by his association by the narrow majority of one to support the motion. In Dr. Rennie's view it was impossible to express definite opinions about a service until details of the plan to be put into operation were given.

Dr. K. S. M. Brown raised the question of freedom of discussion if all members of the profession became public servants and were controlled by a government plan.

Dr. A. L. Caselberg referred to the return of medical practitioners from active service. These men would have to step back into civilian service in the community. They would have to take up work somewhere where they had left it off, and it would be impossible in the opinion of his association to transfer the medical service of the community suddenly to any type of salaried basis.

Dr. R. J. Jackson thought that the members of his association were quite satisfied to extend the present form of medical service in such a way that it would be in the interests of the community, but he said they would resent any idea of control from outside.

Dr. O. J. Ellis was in favour of the motion. He could not see how a salaried service could be run without political control and how it could fail to be subject to the whims and caprices of each party that came into power.

Dr. G. F. Elliott said that his association had tried to consider the matter from the point of view of the public. They could not help feeling that if the alternative to the present type of practice was a whole-time, free for all, no-limit panel system, such a service would not serve the public well. Those among them who had seen the panel system working in England were its strongest opponents. Dr. Elliott said that he would like the association neither to be in favour of a salaried service nor against it. He thought that judgement should be withheld until fuller information was available.

Lieutenant-Colonel S. G. Nelson spoke from the army point of view. He said that army doctors were opposed to any change that would upset the present system of medical practice while they were away, and that also they did not wish to come back to a scheme that would change drastically the conditions of medical service as they understood it.

Dr. J. Cooper Booth admitted that there was a great deal of truth in what Dr. Collins had said, yet he believed that a medical service with a body such as the British Medical Association behind it should give service to the nation which would be of enormous benefit. Dr. Cooper Booth admitted that there was sometimes a certain amount of political interference, but added that occasionally this came from medical men outside the Government service who approached a minister when they did not exactly approve of what was going on. Dr. Cooper Booth had been in the Government medical service for fourteen years, but had not found that his hands were tied a great deal. Of course, much depended on the minister in power at the time in regard to what advice he had and what freedom he gave his medical officers.

Dr. N. E. McLaren agreed that a salaried service might be workable if the salaries were large enough and if enough doctors were engaged to work it. The important thing, however, was whether the community as a whole was going to benefit more by a salaried service than by the present type of service. This was hard to say. He thought that on the whole a salaried service would not be much improvement, if any, on the present conditions.

Dr. H. H. Schlink spoke of the value of the Metropolitan Hospitals Contribution Fund. If this scheme were made compulsory hospital charges would be provided for and only medical fees would have to be considered in the family budget. In regard to medical fees, Dr. Schlink said he had no doubt that the profession still wished to treat in public hospitals those who could not afford to pay for treatment. In regard to persons in the intermediate income groups he thought that the association should establish and conduct a voluntary insurance scheme for medical attendance. The well-to-do might be allowed to take up insurance cover, but they should be given to understand that they would have to make up the difference between the benefit and the usual fees charged by the profession. Dr. Schlink thought that the medical profession should rise to the occasion of controlling its own affairs without interference from interested laymen.

Dr. J. M. Banks said that he had been instructed to vote in favour of the motion.

Mr. J. W. Hornbrook, representing medical undergraduates in the University of Sydney, said that they were absolutely opposed to the introduction of salaried service in the medical profession.

Sir Charles Blackburn said that he was not prepared to agree that the present system of medical practice was doomed. All the health measures that had been undertaken by the Government had been urged upon it over the years by the medical profession, and now the Government asked how things could be altered. All the ancillary services that had grown up around medical practice were a very great burden, especially to people in the middle income group. The profession had to see that these services were made available to the public at a reasonable cost, and if it could not pay, at no cost.

Dr. H. R. R. Grieve made further reference to the lag in the Government's medical services in the introduction of new remedies, mentioned by previous speakers. He insisted that that lag would always militate against the efficiency of a salaried service. The practising doctors of medicine had always outstripped in efficiency the government doctors of medicine.

At this stage Dr. M. H. Elliot-Smith moved an amendment by adding to the original motion the words "and not acceptable to the profession". After discussion this amendment was defeated. Dr. T. M. Greenaway then moved as an amendment the following motion:

That a whole-time salaried basis for a nation-wide medical service as outlined by the National Health and Medical Research Council is not in the interests of the community.

Dr. A. J. Collins pointed out that the Council did not wish to confine the motion to any particular scheme, for it held the view that a salaried medical service was against the interests of the community and was prepared to stand by it. The amendment was defeated.

In the course of his reply Dr. Collins could not agree with those who thought that safeguards would be effective in a salaried medical service. He also announced that the Victorian Branch Council had adopted a resolution condemning a national medical salaried service and opposing the report drawn up by its subcommittee and published in THE MEDICAL JOURNAL OF AUSTRALIA. Dr. Collins's original motion was put to the meeting and carried by an eight to one majority.

#### The Present System of Medical Practice.

Dr. D. G. Carruthers moved:

That no sound reasons have been brought forward to show that there is any necessity for a change from the present system of medical practice, nor is there sufficient evidence to show that such a change would be of benefit to the community.

Dr. J. P. Hardie seconded the motion *pro forma*. After Dr. Carruthers had spoken in favour of the motion, several speakers opposed it, holding that its adoption would give a wrong impression or tend to nullify the holding of the convention. An amendment was moved by Dr. Darcy Williams, suggesting the omission of the words "nor is there sufficient evidence that such a change would be of benefit to the community". The amendment was put and carried, but on being put to the meeting as a substantive motion it was defeated.

Dr. A. J. Collins introduced to the convention a motion dealing with the steps which might be taken in regard to the present form of medical service to make it efficient. A

great deal of discussion took place on every subheading in the motion, and several amendments were proposed, some of them being accepted and some rejected. Among the suggestions which were rejected were some that could not be regarded as constituting part of a medical service, but were ancillary. Eventually the resolution was adopted in the following form:

That the optimum efficiency of medical service to the people of Australia will be provided by the following structure—the existing consultant, general practitioner and hospital services with all adjuncts and these necessary additions:

(a) Safeguarding and improvement of nutritional and housing standards.

(b) Adequate provision for research and statistical investigation.

(c) Decentralized diagnostic laboratory centres throughout the Commonwealth.

(d) An extended consultant service to make ready consultation available to all members of the community.

(e) Group practice initiated by members of the profession themselves.

(f) Extension through government grant of the Flying Doctor Service.

(g) Increased subsidized practitioner service to outback centres.

(h) Extended industrial, venereal, immunological and other preventive medical services.

(i) Extension of the present maternity services.

(j) Extended hospital construction and equipment, with special reference to tuberculosis, mental disease, the crippled, bed-ridden and the aged, and the provision of private and intermediate wards at all public hospitals.

(k) Extension and improvement of standards of post-graduate training with a subsidy to medical practitioners unable otherwise to avail themselves of these facilities.

#### Proposals for the Future Regarding Medical Practice.

On behalf of the Western Suburbs Medical Association, Dr. H. M. Rennie brought forward a motion stating that the profession was unable to express an opinion on the merits or demerits of any form of national medical service until such time as the full details of conditions of service and remuneration were available. After several members had raised the point that the motion conflicted with others that had already come and were yet to come before the convention, the Chairman ruled that the motion was out of order and the convention passed on to the next business.

The next motion was moved on behalf of the Southern District Medical Association by Dr. Glennie Holmes. In this motion were set out certain improvements which the Southern District Medical Association thought ought to be carried out before any extensive change was made in the present system. The improvements suggested did not call for a medical solution. A general discussion took place and representatives pointed out that certain of the defects were particularly noticeable in the areas which they represented. The motion was eventually adopted in the following form:

That in considering improvement in the social services this convention recommends that the following matters be kept in mind:

(a) The establishment of hostels for waiting mothers.

(b) Some provision to enable the wage-earner, when a sufferer from pulmonary tuberculosis, to be treated apart from his family until no longer infectious.

(c) In small towns the ambulance service should be attached to and run by the hospital and not by outside bodies.

(d) Improvement in the medical services to the "middle class".

(e) The extension of invalid pensions, in certain cases, to those temporarily and partially disabled.

(f) Avoidance of the building of unnecessarily elaborate hospitals.

(g) The establishment of old peoples' homes in the country.

(h) The extension and unification of hospital contribution schemes.

Dr. H. M. Rennie moved a motion stating that the Federal Council should be requested to formulate definite plans and details for the modification of the present type of medical practice with particular reference to the establish-

ment and encouragement of private group practice. The motion was seconded by Lieutenant-Colonel S. G. Nelson. Dr. J. N. Chesterman did not think that the Federal Council as it was constituted was the body to formulate such plans and details. He moved an amendment suggesting that the Federal Council should appoint a committee to formulate definite plans and recommendations for the modification of the present type of medical practice. Some discussion took place in regard to the powers of the Federal Council and the number of general practitioners amongst its members. Dr. George Bell pointed out that the Federal Council had power to form committees and that it could also coopt one or more committees for the purpose of carrying out any of its powers, and in fact this was what the Federal Council did. After further discussion the amendment was put to the meeting and lost. Dr. Rennie's motion was carried.

#### Contributory Health Insurance.

A long discussion took place in regard to contributory health insurance. The subject was introduced by Dr. A. J. Collins on behalf of the Council. The motion moved by Dr. Collins stated that the profession was prepared to support a contributory health insurance scheme which embodied certain essential principles. Dr. Collins explained that the motion implied that the profession had a second string to its bow. The convention had already decided the way in which the optimum efficiency of medical service to the people of Australia would be provided. Several amendments were put forward and rejected in turn. In the course of the discussion Dr. J. G. Hunter, the Medical Secretary, spoke at the request of the Chairman. He pointed out that various forms of contributory insurance were already in vogue in the State, though they were known under the title of "contract practice". What the meeting had to decide was whether those present were satisfied with the principles of a contributory insurance. The motion was eventually put to the meeting and carried.

#### Shortening of the Agenda Paper.

At this stage Lieutenant-Colonel S. G. Nelson proposed that the meeting should adjourn so that the executive might undertake the rationalization of the remainder of the motions which were to go before the meeting. The motion was seconded by Dr. J. P. Hardie and carried.

#### Scope of Contributory Scheme.

On the motion of Dr. A. J. Collins, seconded by Dr. George Bell, it was resolved that in any contributory scheme for a general practitioner service the scope of the service should be only partial in character, in regard to both general practitioner and specialist services.

#### Financial Arrangements under a Contributory Scheme.

Dr. A. J. Collins moved and Dr. R. A. R. Green seconded a motion stating that payment for services under a contributory scheme should be on a capitation basis for general practitioners and a pool basis for specialists. This was followed by a discussion on the pool system, and reference was made by several speakers to the method of payment adopted at the present time under the New Zealand system. During the discussion Dr. J. G. Hunter read a long letter from Dr. Jamieson, the Chairman of the New Zealand Health Insurance Committee. Dr. Jamieson's views were not favourable to the system operating in New Zealand. One representative pointed out that the profession in New South Wales was already working on a fee-for-service scheme under Workers' Compensation Schedule E. The advantages of a fee-for-service system were as follows: (a) It would not interfere with any choice of doctor or patients. (b) There would be no difficulty in arranging group practice on a fee-for-service basis. (c) The doctor would not be bound down to anything except satisfactory service to his patients. (d) There would not necessarily be any depreciation in the value of practices. (e) The introduction of a fee-for-service scheme would not necessarily prejudice practitioners who were absent on war service. Eventually the following amendment, afterwards adopted as the substantive motion, was carried:

That it be recommended to the Federal Council that in any proposed scheme wherein a capitation basis is provided for an alternative fee-for-service scheme be incorporated to provide for general practitioners and specialists.

It was also resolved on the motion of Dr. A. J. Collins, seconded by Dr. George Bell:

That the financing of a contributory scheme should be by: (a) flat rate contributions from both single and married persons and (b) government subvention for (i) those persons with small incomes and large families unable to pay, (ii) unemployed, (iii) unemployable.

Dr. A. J. Collins moved and Dr. George Bell seconded the following motion:

That in view of the practical difficulties in enforcing an income limit in any contributory scheme, no income limit be prescribed.

This gave rise to a good deal of discussion. An amendment was moved by Dr. O. J. Ellis, to the effect that though the medical profession was opposed to a general medical service being available to all classes of the community without an income limit, it was prepared to accept an income limit higher than that ruling under the present Common Form of Agreement. This was seconded by Dr. T. W. Lipscomb. Several representatives emphasized the difficulty of enforcing an income limit, and it was also pointed out that some men, for instance, miners, might earn £20 a week for six months of the year and for the next three or six months be practically on the basic wage. Another representative remarked that he had always felt any attempt to try to enforce the income limit with friendly society patients as degrading and unsatisfactory. The amendment, when put to the meeting, was lost, and the original motion was carried unanimously.

It was also resolved on the motion of Dr. A. J. Collins, seconded by Dr. George Barron, that any contributory scheme should be on a compulsory basis.

#### Control of a General Medical Service.

Dr. A. J. Collins moved a motion dealing with the body which was to control a general medical service for Australia. During the discussion Dr. Collins accepted one or two verbal alterations in the motion, and it was eventually carried in the following form:

That in any general medical service for Australia administration should be in the hands of a corporate body and not a government department, which should be composed of (a) non-medical members of knowledge and experience in health matters and nominated on a non-political basis and (b) medical men who shall constitute a majority of the corporate body elected by the practising medical profession.

Dr. C. H. Jaede moved and Dr. B. T. Edye seconded the following motion:

That complete disciplinary control of members accepting service in any scheme shall be exercised by members of the British Medical Association only and that adequate representation shall be given to members of that Association upon the administrative side of the scheme.

In the early part of the discussion Dr. C. H. Jaede and Dr. B. T. Edye agreed to delete the last words of the motion, "and that adequate representation" *et cetera*.

Dr. H. R. R. Grieve pointed out that it was a principle embodied in medical registers everywhere within the Empire that the power of discipline over doctors registered should lie with the statutory body. He did not think that any government could reasonably be expected to surrender that right. Neither did he think that it was in the interests of the people that they should do so, much less should they surrender the right to a body which had no statutory significance—a body organized within the profession itself. Dr. J. G. Hunter pointed out that in England, under the provisions of the *National Health Insurance Act*, the panel committees were composed of medical practitioners and had no statutory powers. The matters referred to by Dr. Grieve were those which had to do with the professional conduct of any medical practitioner and were dealt with by medical boards. The motion was put to the meeting and carried.

#### Schemes of Medical Service and the War.

It was resolved on the motion of Dr. C. H. Jaede, seconded by Dr. A. D. Morgan:

That if any scheme be formulated during hostilities, full opportunity for its consideration must be offered to the profession, including those in the fighting forces, prior to its acceptance by the Federal Council.

Dr. D. G. Carruthers moved and Dr. R. A. Robertson seconded a motion in regard to the change in the status of the medical profession during the war. The motion was adopted in the following form:

That this convention is opposed to any change being made in the status of the medical profession and conditions of medical practice during the currency of the war or for the period of one year after its termination, and that the Federal Council be instructed to oppose it by all possible means.

#### Schemes of Medical Service and Compensation.

Dr. J. C. Hardie moved and Dr. A. M. Davidson seconded the following motion:

That in the event of the adoption of any scheme which destroys the equity of medical practice adequate financial compensation should be made.

Dr. Hardie pointed out that the medical profession had a vested interest in the prevention of disease, but it also had a vested interest in a financial sense, and in the event of the introduction of certain types of medical service compensation would be required for its loss. This vested interest represented the value of the goodwill of practices and in some instances represented the whole of a man's life savings. The motion was carried.

#### Specialist Practice in Relation to General Medical Service Schemes.

On the motion of Dr. Darcy Williams, seconded by Dr. D. G. Carruthers, it was resolved that any scheme for general medical service which affected specialist practice should first be referred to the specialist bodies concerned for consideration prior to its acceptance by the Federal Council.

#### A Proposed Referendum on General Medical Service Schemes.

Dr. G. L. Howe moved on behalf of the Kuring-gai District Medical Association, and Dr. R. A. Robertson seconded, a motion stating that before the Federal Council gave its approval to any alteration of the system of medical service in Australia, a referendum should be submitted to all the members of the Association. This gave rise to some discussion. One representative stated that he was opposed to it because the decision was handed to a number of men who never attended a meeting and had given no thought to the subject. He also said that with men in the armed forces questions of practice in civilian life receded very much into the background. Other representatives said that past experience of referenda had not been happy. Another pointed out that very few members of the Association would answer a referendum. The motion was put to the meeting and lost.

#### Hospital Practice.

Dr. J. E. F. Deakin proposed and Dr. H. R. R. Grieve seconded the following motion, which was carried without discussion:

That a complete survey of hospital bed requirements with special reference to the relative urgency in particular localities and for particular classes of institutions be made through a commission of inquiry to be set up in each of the States, in order that future construction shall proceed in relation to community needs and moneys be allotted in order of urgency.

#### Gynaecology and Obstetrics in the Formulation of Medical Schemes.

It was resolved on the motion of Dr. J. N. Chesterman, seconded by Dr. A. M. Davidson:

That this convention is of the opinion that a representative of the specialty of gynaecology and obstetrics in Australia should be included in any body to consider any medical planning of national medical service.

#### Conclusion of the Convention.

After Dr. J. A. Cahill and Dr. David Roseby had addressed the convention expressing appreciation of the way in which it had been organized and conducted, Dr. W. F. Simmons thanked the representatives for their attendance.

On the motion of Dr. R. J. Jackson a vote of thanks was accorded to Dr. W. F. Simmons for having presided at the meeting.

#### SCIENTIFIC.

A MEETING of the New South Wales Branch of the British Medical Association was held on August 20, 1942, at Lewisham Hospital. The meeting took the form of a series of clinical demonstrations by members of the honorary medical staff of the hospital.

#### Parathyroid Tumour.

DR. R. ST. JOHN HONNER, in conjunction with Dr. R. G. S. HARRIS and Dr. J. D. HERLIHY, showed a patient, aged twenty-two years, who had a history of having sustained three fractures in seven years, and of having suffered from vesical calculi in 1938 and 1939. An X-ray examination was made, and the radiologist reported that there appeared to be a general absorption of calcium from all the bones, especially from the spine, pelvis and upper parts of the femora. A calculus was present in the left ureter. On April 16, 1942, the calcium content of the blood was estimated at 15.9 milligrammes per 100 cubic centimetres and the phosphorus content of the blood at 2.5 milligrammes per 100 cubic centimetres.

On May 27 operation was undertaken. A wide exposure was made through a collar incision, and a parathyroid tumour was removed from behind the left upper pole of the thyroid gland. No other tumour was found. Pathological examination of a section of the tumour revealed it to be an adenoma of the parathyroid gland.

After the operation a parathyroid crisis occurred; the blood calcium content rose to 28 milligrammes per 100 cubic centimetres and the blood phosphorus content fell to 1.78 milligrammes per 100 cubic centimetres. However, by June 12 the blood calcium content had fallen to 11.25 milligrammes and the blood phosphorus content had risen to 3.12 milligrammes. A further examination was made on August 15, when the blood calcium content was found to be 10.33 milligrammes per 100 cubic centimetres and the blood phosphorus content 3.67 milligrammes per 100 cubic centimetres.

#### Double Hepatic Hydatid Cyst.

Dr. Honner then showed a child, aged eleven years, who had been sent to hospital from a country town. A swelling was present below the right costal margin and the Casoni test produced a positive reaction. An X-ray examination revealed two annual shadows, each the size of an orange, in the liver; one was below the diaphragm and the other projected below the right costal margin.

At operation the lower cyst was emptied through a Kocher's incision and the second was then emptied through the cavity of the first. The wound was closed without drainage, and the patient made normal progress.

#### Macrocytic Anaemia following Partial Gastrectomy for Carcinoma.

Dr. Honner's third patient had undergone partial gastrectomy for carcinoma on March 18, 1942, and had been discharged from hospital on April 4. On June 21 readmission to hospital became necessary, on account of severe pallor and breathlessness. A blood count revealed that the haemoglobin value was 29%; the erythrocytes numbered 1,250,000 per cubic millimetre, and 0.1% were reticulocytes. Treatment with "Campolon" was begun, 2.0 cubic centimetres being given every second day. On July 16 a blood count revealed that the haemoglobin value was 70% and the erythrocytes numbered 3,440,000 per cubic millimetre, 4.8% being reticulocytes.

#### Carcinoma of the Rectum.

Dr. Honner finally showed a man, aged thirty-five years, who had undergone surgical treatment for a large tumour of the pelvi-rectal junction. At a preliminary operation, "defunctioning" of the distal part of the colon was ensured by the formation of "disconnecting anus" after the method of Devine. Three weeks later, on May 28, 1941, abdomino-perineal resection of the rectum and sigmoid colon was carried out. At the time of the meeting the patient was at work, and weighed more than at any previous period.

#### Malignant Tumours.

DR. ALAN F. OXENHAM showed a series of patients suffering from different types of sarcoma and carcinoma.

**Congenital Abnormalities.**

Dr. Oxenham also showed several different types of congenital abnormalities.

**Urological Demonstration.**

Dr. Oxenham, in conjunction with Dr. R. G. S. HARRIS, also showed pyelograms and uograms of renal tumours and of renal, ureteral and vesical calculi.

**Correspondence.****SEMINAL CHANGES AFFECTING FERTILITY.**

SIR: In reference to my letter on "Seminal Changes Affecting Fertility" so kindly published by you in your issue of December 26, 1942, the word "microscopically" should read "macroscopically" in paragraph 3.

Yours, etc.,

February 4, 1943.

R. MACKAY.

**THE TREATMENT OF LARGE SOFT TISSUE INJURIES BY EXCISION AND PRIMARY SUTURE.**

SIR: In his paper (*THE MEDICAL JOURNAL OF AUSTRALIA*, February 13, 1943) W. A. Hailes confuses principles with what are mere expedients; no principles are involved in the methods he compares and his complacency is prodigious. He declares that excision cannot be depended upon to sterilize a wound and that we have no reagent that will of certainty destroy infection in a wound. So he condemns excision and primary suture in most situations and admits that the closed plaster method has end results which test the skill of the orthopaedic surgeons to the uttermost. Secondary infection is responsible for all this and that, yet he clings to his expedients. I am really sorry for the "junior" for whom this paper was written as he is suspended between time-lag, the devil and the "blue"—almost crucified! Wishful thinking and hoping are no good; an unprincipled risk must be taken by the "junior" whatever method he chooses. Will no surgeon make the attempt to exclude secondary infection and so give natural tissue resistance full play? By these means the element of risk is eliminated by the only sound principle to guide us.

Yours, etc.,

A. C. F. HALFORD.

Brisbane,  
February 16, 1943.

**PROBLEMS OF INFANT FEEDING.**

SIR: I am writing to correct a statement made by your correspondent, Dr. E. B. Fitzpatrick, in his recent letter about infant feeding. He refers to the "Tresillian system" of infant feeding. There is no such system. All infant feeding is based on certain principles which may be stated shortly. (i) The infant must receive sufficient Calories so that the energy value of the food consumed corresponds with the total energy value of the output in work (activity), heat, growth *et cetera*. (ii) From 10% to 15% of the total Calories should come from protein, the remaining Calories being supplied by carbohydrate and fat. (iii) The fluid requirement of the infant is estimated at two and a half ounces per pound body weight and this is supplied in a mixture containing approximately 20 Calories to the ounce. (iv) Vitamins and salts must be provided in adequate amounts. (v) The food must be in such a form that it can be digested and absorbed by the infant. On this basis we can build up a satisfactory diet, not only for the normal infant, but also for those who require special treatment. It is on this basis that the mixtures used in the baby health centres are made up. The nurses are instructed to refer any infant who is not doing well to their medical adviser who is expected to suggest modifications of the feeding to suit the individual baby. To carry out infant feeding with intelligence it is necessary to know the percentage composition of the mixtures and the foods used as well as their caloric value, that is, we should know what we are using

and why we are using it. For those medical practitioners who wish to direct the feeding of the infants under their care with interest and intelligence I would recommend the "Guide to Infant Feeding" compiled by Dr. Vera Scantlebury Brown and published by the Public Health Department of Victoria. In this publication they will find the percentage composition and the caloric value of the commonly used foods as well as other helpful information. I should like to express my appreciation of the letter of your correspondent, Dr. F. S. McDonald, drawing attention again to the value of breast feeding. As he points out, the nursing mother for many reasons should receive greater consideration from the community in these days of restriction.

Yours, etc.,

MARGARET H. HARPER.

British Medical Association House,  
137, Macquarie Street,  
Sydney.

February 17, 1943.

**SEX AND SOCIETY.**

SIR: The New South Wales Division of the Australian Association of Scientific Workers has established a sub-committee to examine the problems of sex and society and suggest reforms.

The aims of this subcommittee will be: (a) to foster a scientific approach to the problems of sex and the individual and sex and society; and (b) to investigate the possibilities of introducing scientific sex education wherever it is needed. It shall attempt to do this by: (i) preparing material for dissemination by all possible media; (ii) exposing unscientific explanations and statements on these matters; (iii) establishing groups, study circles and lectures; and (iv) cooperating with other organizations interested and to interest others which could play a part in the campaign.

As we are anxious to receive suggestions and helpful criticism from persons interested in this subject, we should be glad if you would afford us the space in your columns for publication of this letter.

Yours, etc.,

S. L. MACINDOE,

Chairman, New South Wales Division,  
Australian Association of Scientific  
Workers.

Box 3658S,  
G.P.O.,  
Sydney.  
February 18, 1943.

**THE STAINING OF THE THICK DROP OF BLOOD.**

SIR: Could I be permitted to add a few words to Dr. A. E. Flinch's letter about Schilling's method of "the staining of the thick drop of blood", which appeared in the issue of *THE MEDICAL JOURNAL OF AUSTRALIA*, dated February 13, 1943.

The following modification gives the same results as Schilling's original method, but is easier to carry out:

1. Place a drop of blood on a slide and without spreading allow it to dry. The less the area to be examined, the quicker parasites can be found.

2. Make diluted Giemsa's stain (15 drops to 10 cubic centimetres of distilled water) and cover the film. Leave it for thirty minutes. By this time the whole haemoglobin will be collected on the surface of the stain.

3. Pour off the stain. Wash the film very carefully with water (tap water can be used). Drain until dry and examine under oil immersion.

Yours, etc.,

S. G. Ross.

Microbiological Laboratory,  
93, Macquarie Street,  
Sydney.  
February 19, 1943.

**GASTRO-ENTERITIS AND THE BOILING OF MILK.**

SIR: During the recent epidemic of gastro-enteritis I have been informed by a large proportion of the mothers, also by the mother of one child with tuberculosis of the mesenteric glands of the hip joint, that they do not boil the milk before giving it to their children. Many of them

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have neglected this precaution because they have heard from the "clinic" that the milk need not be boiled for children after the age of three years. Who is responsible for this advice?

Would it not be better for our children if the "clinic" nurses hearkened to and appreciated the advice of that dozen of paediatricians, the late Sir Frederick Still, who wrote in his great text-book: "Now on this point I wish to speak with no uncertain voice, and the more so, as I have often been responsible in former years for the usage of raw milk, that is, milk unheated except to the feeding temperature of 100° F. Not only throughout infancy, but throughout the whole period of childhood, the use of raw milk is attended with very serious danger, a danger which, in my opinion, altogether outweighs the disadvantages of heating the milk by pasteurization, boiling or sterilization."

Yours, etc.,

"PRACTITIONER."

Sydney,  
February 23, 1943.

## THE FUTURE OF MEDICAL PRACTICE.

SIR: A great deal of time and thought is being expended considering the provision of a better medical service to the community, and a radical change in the present relationships of doctor to patient is threatened.

Dr. H. R. R. Grieve, in his evidence to the Parliamentary Joint Committee (THE MEDICAL JOURNAL OF AUSTRALIA, February 20, 1943), claims that it would be better to improve "the present admittedly high standard of service" by extending facilities for improved diagnosis and prevention of disease. I agree with him, and would draw attention to one obvious way of doing this.

Whatever form of service eventuates it will fall far short of doing its utmost for the public until every death is investigated by post-mortem examination.

How much is lost to medical knowledge through lack of such investigation? How often do we wish for a post-mortem examination? How many of our death certificates are even reasonably correct?

In these enlightened times when social service is so much talked of, is it not absurd that we should neglect such a great opportunity to advance our knowledge?

We should have full-time pathologists appointed to suitably sized districts throughout the Commonwealth, who would undertake post-mortem investigations at basic centres (hospitals) in all cases, and who would consult with the medical attendants concerned before certification.

Then we would really learn much that would benefit humanity—more in 12 months perhaps than in 12 years under present circumstances.

Yours, etc.,

W. R. GROVES.

Niddrie,  
Kyneton,  
Victoria.  
February 23, 1943.

## THE SCURVY PROBLEM OF TODAY.

SIR: Excellent as are the orange and other citrus fruits as a source of vitamin C, too much stress has been laid on their scarcity. The juices of tomatoes and pineapples can be used equally well, and there are other substitutes such as the juice of swede turnips. Neither is Australia wholly destitute of black currants and rose hips. Tablets of ascorbic acid, though no doubt valuable for emergency and occasional use, have serious disadvantages. The reason is simple.

It is of the first importance that all necessary vitamins should be provided in the food. To give them as a routine in tablet form suggests that they are medicines for temporary use only. Especially would this have a harmful effect on the psychology of our mothers, who have been mis-educated by long and persistent advertising of "teething powders" and other "medicines". Most of the troubles of infancy are the result of wrong notions that have got into mothers' heads, and the routine issue of what will be regarded, in spite of anything the clinic nurses may say, as a new teething powder, will not improve children's health.

Yours, etc.,

A. JEFFRIES TURNER.

Brisbane,  
February 23, 1943.

## Naval, Military and Air Force.

## APPOINTMENTS.

THE undermentioned appointments, changes et cetera have been promulgated in the *Commonwealth of Australia Gazette*, Number 38, of February 18, 1943.

## ROYAL AUSTRALIAN AIR FORCE.

## Citizen Air Force: Medical Branch.

The probationary appointments of the following Flight Lieutenants (temporary Squadron Leaders) are confirmed: H. S. Lucraft (6376), W. N. Little (6410), J. B. Turner (6425).

The probationary appointments of the following Flight Lieutenants are confirmed: F. W. Kiel (3233), G. F. Salter (3256), J. H. Smith (3338), H. R. Clegg (3408), K. W. MacLeod (3453), K. F. Brennan (3473), M. V. Clarke (3717), J. P. Fleming (3942), L. J. Ray (3941), A. P. Cahill (4367), C. H. Chambers (4904), J. Beaumont-Haynes (5168), W. R. Dalton (5172), C. P. Harrison (5173), M. M. McKeown (5912), E. Dennis (6288), O. W. Bowering (6170), R. E. Woods (6330), W. A. Leventhal (3409), N. J. Royle (4369), R. C. Opie (3435), A. J. Lundie (3436), J. C. Lane (3728), D. A. Brown (4262), R. H. Edwards (3892), F. H. Read (3891), I. Filshie (6383), V. W. Pennington (6384), L. E. Goldsmith (4853), F. K. Bartlett (5167), P. J. Bird (5169), E. W. Lee (6050), B. W. Costello (5909), J. W. L. Atkinson (1414).

## Reserve: Medical Branch.

The following are appointed to commissions on probation with the rank of Flight Lieutenant, with effect from the dates indicated: Philip Cornelius Hogan, M.B., B.S., F.R.C.S. (7234), 30th November, 1942; Garth Jewett Blunden Phillips, M.B., B.S. (7374), Arthur Culton Schwieger, M.B., B.S. (7345), Archibald Binnie Yuille, M.B., B.S. (7346), 14th January, 1943.—(Ex. Min. No. 52—Approved 17th February, 1943.)

## CASUALTIES.

ACCORDING to the casualty list received on February 23, 1943, Captain R. D. Puslett, A.A.M.C., Milson's Point, who was previously reported missing, is now reported to be a prisoner of war.

According to the casualty list received on February 25, 1943, Captain R. A. McDonald, A.A.M.C., Eastwood, who was previously reported missing, believed prisoner of war, is now reported to be a prisoner of war.

According to the casualty list received on March 1, 1943, Major G. E. Jose, A.A.M.C., Woodville, South Australia, who was previously reported missing, is now reported "believed deceased".

## Australian Medical Board Proceedings.

## QUEENSLAND.

THE undermentioned have been registered, pursuant to the provisions of *The Medical Acts*, 1939-1940, of Queensland, as specialists in surgery:

McCafferty, George Henry, Penneys' Building, Queen Street, Brisbane.

Fowles, Duncan, Woongarra Street, Bundaberg.

Saxton, William John, Kingaroy.

Luddy, John Joseph, Ascot Chambers, Edward Street, Brisbane, Queensland.

Meade, Frampton Garnsey, Bellevue Terrace, Clayfield, Queensland.

Helmsley, James Cameron, on active service.

The undermentioned has been registered, pursuant to the provisions of *The Medical Acts*, 1939-1940, of Queensland, as specialist in hygiene:

Weaver, Ralph Edward, Sherwood Road, Sherwood.

The undermentioned has been registered, pursuant to the provisions of *The Medical Acts*, 1939-1940, of Queensland, as specialist in pediatrics:

Fison, David Charles, 59, O'Connell Street, Kangaroo Point.

The undermentioned have been registered, pursuant to the provisions of *The Medical Acts, 1939-1940*, of Queensland, as specialists in ophthalmology:

Dart, John Leslie, on active service.  
 Dolman, Edgar Winn Fox, 55, Wickham Terrace, Brisbane, Queensland.  
 McSweeney, Daniel Christopher, General Hospital, Brisbane.

The undermentioned has been registered, pursuant to the provisions of *The Medical Acts, 1939-1940*, of Queensland, as specialist in anaesthetics:

McAllister, Robert John, Morrison Road, Eagle Junction.

## Obituary.

### CECIL STANLEY MOLESWORTH.

We regret to announce the death of Dr. Cecil Stanley Molesworth, which occurred on February 24, 1943, at Campbelltown, New South Wales.

## Medical Appointments.

The undermentioned have been appointed Honorary Clinical Assistants (Surgical Section) at the Royal Adelaide Hospital, Adelaide, South Australia: Dr. Noel James Bonnin, Dr. Joseph Ruskin Cornish, Dr. Oswald Westcott Frewin, Dr. Andrew John Hakendorf, Dr. Garton Maxwell Hone, Dr. Wallace Wilson Jolly, Dr. Gilbert Edgar Jose, Dr. Thomas Davis Kelly, Dr. Sydney Krantz, Dr. Bruce Ernest Lawrence, Dr. James Davidson Mill, Dr. Owen Meredith Moulden, Dr. Neill Horace Munday, Dr. Alistair Campbell McEachern, Dr. Douglas Gordon McKay, Dr. Leonard James Ternouth Pellew, Dr. Henry Gordon Prest, Dr. John Love Steele Scott, Dr. George Herbert Solomon, Dr. Alan Hubert White.

Dr. William Gilfillan and Dr. Leslie Wadmore Linn have been appointed Honorary Clinical Assistants (Dermatological Section) at the Royal Adelaide Hospital, Adelaide, South Australia.

Dr. Bertram Speakman Hanson and Dr. Bronte Creagh Smeaton have been appointed Honorary Clinical Assistants (X-Ray Section) at the Royal Adelaide Hospital, Adelaide, South Australia.

Dr. Bertram Speakman Hanson and Dr. William Gilfillan have been appointed Honorary Clinical Assistants (Radium Section) at the Royal Adelaide Hospital, Adelaide, South Australia.

Dr. Thomas Leslie McLarty and Dr. Samuel Pearlman have been appointed Honorary Clinical Assistants (Ophthalmological Section) at the Royal Adelaide Hospital, Adelaide, South Australia.

Under the provisions of the *Science and Industry Research Act, 1920-1939*, and on the nomination of the Australian National Research Council, Dr. F. M. Burnet has been appointed a member of the Victorian State Committee for the period terminating on November 8, 1945.

Dr. John William Rollison has been reappointed Medical Superintendent of the Royal Adelaide Hospital, Adelaide, South Australia.

Dr. Walter John Westcott Close has been appointed a member of the Dental Board of South Australia.

Dr. William Richards Tonkin has been appointed a public vaccinator in the Department of Public Health, Victoria.

Dr. Ernst Flaum has been appointed Temporary Honorary Medical Officer in charge of the electrocardiograph at the Royal Adelaide Hospital, Adelaide, South Australia.

Dr. Kenneth Barnden Brown has been appointed a resident medical officer at the Royal Adelaide Hospital, Adelaide, South Australia.

## Books Received.

"Sulfanilamide and Related Compounds in General Practice", by Wesley W. Spink, M.D., F.A.C.P.; Second Edition; 1942. Chicago: The Year Book Publishers, Incorporated. 8 $\frac{1}{2}$ " x 5 $\frac{1}{2}$ ", pp. 374, with illustrations. Price: \$3.00.

"Textbook of Medicine", by various authors, edited by J. J. Conybeare, M.C., D.M. (Oxon.), F.R.C.P.; Sixth Edition; 1942. Edinburgh: E. and S. Livingstone. 8 $\frac{1}{2}$ " x 5 $\frac{1}{2}$ ", pp. 1167, with illustrations. Price: 28s. net.

"Advice to the Expectant Mother on the Care of Her Health and that of Her Child", by F. J. Browne, M.D., D.Sc., F.R.C.S.E., F.R.C.O.G.; Sixth Edition; 1942. Edinburgh: E. and S. Livingstone. 7 $\frac{1}{2}$ " x 4 $\frac{1}{2}$ ", pp. 51. Price: 6d. net.

"Food, Health, Vitamins", by R. H. A. Plimmer, D.Sc. (London), and Violet G. Plimmer; Ninth Edition; 1942. London: Longmans, Green and Company Limited. 7 $\frac{1}{2}$ " x 5", pp. 200, with coloured frontispiece and two diagrams. Price: 7s. 6d.

"The Hemorrhagic Diseases and the Physiology of Hemostasis", by Armand J. Quick, Ph.D., M.D.; First Edition; 1942. Springfield: Charles C. Thomas. 9 $\frac{1}{2}$ " x 6 $\frac{1}{2}$ ", pp. 359, with 24 illustrations and 9 tables. Price: \$6.00, post paid.

## Diary for the Month.

- MAR. 9.—New South Wales Branch, B.M.A.: Executive and Finance Committee; Ethics Committee.  
 MAR. 9.—Tasmanian Branch, B.M.A.: Branch.  
 MAR. 12.—Queensland Branch, B.M.A.: Council.  
 MAR. 15.—Federal Council, B.M.A.: Meeting at Melbourne.  
 MAR. 16.—New South Wales Branch, B.M.A.: Medical Politics Committee.  
 MAR. 17.—Western Australian Branch, B.M.A.: Branch.  
 MAR. 23.—New South Wales Branch, B.M.A.: Council Quarterly.  
 MAR. 25.—New South Wales Branch, B.M.A.: Annual Meeting.  
 MAR. 25.—South Australian Branch, B.M.A.: Branch.  
 MAR. 26.—Queensland Branch, B.M.A.: Council.  
 MAR. 30.—New South Wales Branch, B.M.A.: Council.

## Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

## Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this journal. The management cannot accept any responsibility unless such a notification is received within one month.

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